Child Study Center
Cook Children's

Dear Parent/Guardian:

We are pleased that you are considering the services of Child Study Center for your child. In order to process your application, please provide ALL of the information requested below:

_____1. Child and Family Information
_____2. NICHQ Vanderbilt Assessment Scale – Parent Informant
_____3. School Questionnaire & Vanderbilt Scale – **from your child's current teachers**
_____4. Copy of Insurance Card – **both sides of card must be photocopied**
_____5. Financial Information (**IF** applying for sliding scale, please include tax return)
_____6. Authorization to Request Health Information be Released to Child Study Center
_____7. Copies of Custody Papers, if applicable. **Must contain judge's signature**
_____8. Other: **Copies of all previous educational testing and medical records related to developmental or behavioral testing**

We will be unable to schedule appropriate services for your child until ALL completed information has been received.

A Client Services specialist may be reached at **(682) 303-9300** for any questions regarding your application.

PLEASE NOTE:
After receiving all of your information, your application will be reviewed.
Child Study Center focuses on the evaluation and treatment of children with developmental disabilities. If your child's needs are not within the scope of our services, we will provide you with a list of appropriate community resources.

Mail completed application to:
Client Services Specialist
Child Study Center
1300 West Lancaster Avenue
Fort Worth, TX 76102

Visit us online at: www.cscfw.org

CHILD AND FAMILY INFORMATION

PLEASE PRINT IN BLACK INK

HAS THIS CHILD PREVIOUSLY BEEN SEEN AT CSC? □YES □NO TODAY'S DATE: _____

CHILD INFORMATION

LAST NAME_____FIRST_____MIDDLE_____
DATE OF BIRTH_____ AGE _____ GENDER ___ SS# ____ - ____ - _____ ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____ COUNTY_____
LENGTH OF TIME AT CURRENT ADDRESS_____ PRIMARY PHONE _____

ETHNICITY: □Hispanic or Latino □Not Hispanic or Latino

RACE: □American Indian or Alaska Native □Asian □Black or African American
□Native Hawaiian or Other Pacific Islander □White

LANGUAGE SPOKEN BY THE CHILD_____WILL YOU NEED A TRANSLATOR? □YES □NO
WHICH LANGUAGE SHOULD BE SPOKEN BY THE TRANSLATOR? _____

REFERRAL DOCTOR INFORMATION

CHILD REFERRED BY_____PHONE#_____
DOCTOR'S ADDRESS_____CITY_____STATE_____ZIP CODE_____

PARENT/GUARDIAN INFORMATION

WHO DOES THE CHILD LIVE WITH? _____
IS THIS THE LEGAL GUARDIAN? □YES □NO RELATIONSHIP TO CHILD_____

MOTHER/GUARDIAN FULL NAME_____MARITAL STATUS_____

DATE OF BIRTH_____SS#_____EMPLOYER_____

PRIMARY PHONE#_____ □ cell □ home OTHER PHONE#_____ □ cell □ home

EMAIL _____ □*YES, I would like to be added to your email list for updates about Child Study Center. I understand my information will be kept confidential, and I can unsubscribe at any time.*

FATHER/GUARDIAN FULL NAME_____MARITAL STATUS_____

DATE OF BIRTH_____SS#_____EMPLOYER_____

PRIMARY PHONE#_____□ cell □ home OTHER PHONE# _____ □ cell □ home

EMAIL_____ □*YES, I would like to be added to your email list for updates about Child Study Center. I understand my information will be kept confidential, and I can unsubscribe at any time.*

EMERGENCY CONTACT (NEAREST RELATIVE NOT LIVING WITH YOU):

NAME_____RELATIONSHIP_____PHONE# _____

HOUSEHOLD MEMBERS

NAME_____AGE_____RELATIONSHIP_____CSC CLIENT □YES □NO
NAME_____AGE_____RELATIONSHIP_____CSC CLIENT □YES □NO
NAME_____AGE_____RELATIONSHIP_____CSC CLIENT □YES □NO
NAME_____AGE_____RELATIONSHIP_____CSC CLIENT □YES □NO
NAME_____AGE_____RELATIONSHIP_____CSC CLIENT □YES □NO

PLEASE CIRCLE FAMILY INCOME *(FOR UNITED WAY PURPOSES ONLY)*

$0-$20,750 $20,751-$34,599 $34,600-$55,349 $55,350 and over

Patient's Initials ___

I. IN THE SPACE BELOW, PLEASE LIST THE MAIN CONCERNS THAT YOU HAVE FOR YOUR CHILD (Please describe why you are applying, and what questions you have about your child)

1. Please check the following reasons you are applying to the Child Study Center:
   - □For an evaluation of my child's attention or hyperactivity problems.
   - □For an evaluation of my child's learning problems (including dyslexia, math, writing).
   - □For an evaluation of my child's developmental delays (language, social skills, motor skills).
   - □For an evaluation to determine if my child has autism.
   - □To talk to a doctor about my child's current medications.
   - □For a second opinion of my child's diagnosis, which is _____
   - □I am interested in the ABA behavioral program for children ages 3-8 who have autism.
   - □I am interested in the Jane Justin special education school for children ages 3-12 years old.
   - □I am interested in the Behavior Disorders Clinic (BDC) for children with Autism
   - □Other reasons (describe): _____
2. Please mark if your child has: □Tried to hurt/kill himself/herself □ Tried to hurt/kill others □Had extreme temper tantrums or meltdowns
3. When did your child's problems begin? _____
4. What is your child's medical or psychiatric diagnosis? _____
5. What medications does your child take regularly? _____
6. Does your child receive special education? □YES □NO If yes, what is the classification?
   □Autism □Intellectual disability □PPCD □Speech impairment □Specific learning disability
   □Other health impaired □Emotional disturbance □Behavioral disturbance □Traumatic brain injury
7. Is your child currently receiving any of the following?
   □ECI □ABA Therapy □Speech Therapy □Physical Therapy □Occupational Therapy
   □Counseling □504 Accommodations □Attends private school
8. Do you want your child to see a specific doctor? If yes, which doctor? _____

II. PREGNANCY AND BIRTH HISTORY

1. Was this child adopted? □YES □NO If yes, how old when you took him/her home? _____
2. Length of pregnancy: _____ weeks Birth weight: _____lbs. ___ozs.
3. Mother's age at time of pregnancy: ___ Father's age at time of pregnancy ___
4. Number of pregnancies of child's biological mother: ___
5. Prenatal care began: ___1st trimester ___2nd trimester ___3rd trimester ___None
6. How much weight did the mother gain during pregnancy? ___ lbs.

7. Problems with pregnancy **[please check (✓), if applicable]**:
   a. Bleeding/spotting..... ___
   b. Diabetic state in pregnancy (sugar in urine)..... ___
   c. High blood pressure..... ___
   d. Alcohol used..... ___
   e. Tobacco used..... ___
   f. Toxic exposures..... ___If checked (✓), explain _____
   g. Infections..... ___If checked (✓), explain _____
   h. Prescribed medications..... ___If checked (✓), explain _____
   i. Other drugs used..... ___If checked (✓), explain _____
   j. Other problems _____
8. Labor: □Induced □Spontaneous How long was the labor? ____ hours
9. Delivery: □Vaginal □Forceps used □Vacuum assisted □Caesarian
10. If Caesarean, why? □Scheduled □Failure to progress □Emergency _____
11. At what hospital was the baby born?_____
12. The baby stayed in the: □Regular nursery □NICU Discharged at____days of life
13. Problems in the nursery **[please check (✓), if applicable]**:

__Problems breathing	__Infections/sepsis
__High blood sugar	__Seizures
__Low blood sugar	__Feeding problems
__Jaundice	__High temperature
__Heart problems	__Low temperature

IN THE BOX BELOW, PLEASE EXPLAIN ANY OTHER IMPORTANT INFORMATION ABOUT YOUR CHILD'S BIRTH:

III. HEALTH/MEDICAL HISTORY

1. Who is your child's doctor? Doctor's Name_____
2. Does your child see a neurologist? □YES □NO If yes, name_____
3. Does your child see a psychiatrist? □YES □NO If yes, name _____
4. Does your child see a counselor? □YES □NO If yes, name _____
5. Does your child currently take medications (prescription/non-prescription) on a regular basis? □YES □NO
   If yes, which medications? _____
6. What other medications has your child previously taken? _____
7. Has your child been hospitalized? □YES □NO If yes, describe _____
8. Has your child had any surgeries? □YES □NO If yes, describe _____

Patient's Initials ___

9. Has your child ever had a psychiatric hospitalization? □YES □NO If yes, describe _____
10. Are there other medical problems? □YES □NO If yes, describe _____
11. Has your child had any serious injuries, especially with loss of consciousness? □YES □NO If yes, describe _____
12. Does your child have respiratory allergies or asthma? □YES □NO If yes, describe _____
13. Does your child have allergies to medications or foods? □YES □NO If yes, describe _____
14. Are your child's immunizations current? □YES □NO If no, explain _____
15. Does your child have eating problems? □YES □NO If yes, describe _____
    Have you modified your child's diet because of the problems? If so, please describe in the box below:

IV. REVIEW OF SYSTEMS Please check (✓) if your child has any history of:

□Seizures	□Sleep difficulties
□Staring episodes	□Headaches
□Motor/vocal tics	□Vision problems
□Bowel problems	□Hearing problems
□Bladder problems	□Drooling
□Ear infections	□Chewing problems
□MRI or CT scan	□Swallowing difficulties
Previous hearing/audiology test results:	□Normal □Abnormal
Previous seeing/vision test results:	□Normal □Abnormal

IN THE BOX BELOW, EXPLAIN ANY OTHER IMPORTANT MEDICAL HISTORY OF YOUR CHILD, INCLUDING ANY HISTORY OF MEDICAL TESTS THAT HAVE BEEN PREVIOUSLY COMPLETED:

Patient's Initials___

V. FAMILY HISTORY

1. HISTORY OF BIOLOGICAL MOTHER
   Education: □Did Not Graduate □GED □High School □Some college □Associate's □Bachelor's □Advanced
   Mother's Occupation: _____
   Please indicate if the child's biological mother had/has a history of:
   □Speech Problems □Learning Problems □Dyslexia □Attention Problems □Depression □Anxiety □Bipolar Disorder

2. HISTORY OF BIOLOGICAL FATHER
   Education: □Did not graduate □GED □High School □Some College □Associate's □Bachelor's □Advanced
   Father's Occupation: _____
   Please indicate if the child's biological father had/has a history of:
   □Speech Problems □Learning Problems □Dyslexia □Attention Problems □Depression □Anxiety □Bipolar Disorder

3. PARENTS' MARITAL STATUS/VISITATION
   Child's parents are: ___Never married ___Separated ___Divorced ___Married to each other ___
   If separated or divorced, who has primary custody? _____
   How often does the child see the non-custodial parent? __Regularly __Sometimes___

4. CHILD'S CURRENT LIVING SITUATION
   Who is the primary caretaker?_____
   How long at current address? ____years □House □Apt □Trailer □Own □Rent

5. HISTORY OF BIOLOGICAL SIBLINGS
   Do any biological siblings have learning, speech, behavior, or other problems? □YES □NO
   If yes, describe _____

6. STRESSORS Mark (✓) if your child has experienced:

___Parent separation or divorce	___Moves to different homes
___Moves to different schools	___Family financial difficulties
___Multiple absences/tardies	___Social problems or bullying
___Loss/death of family member	___Loss/death of friend or pet
___Exposure to trauma	

7. FAMILY HISTORY Mark (✓) if anyone on child's mother's OR father's side of the family has a history of:

___Learning disabilities/Dyslexia	___Attention Deficit Hyperactivity (ADHD)
___Slow learners	___Intellectual disability
___Speech/language disorders	___Autism/Asperger's/PDD-NOS
___Seizures	___Alcoholism
___Drug abuse	___Anxiety/extreme worrying
___Depression	___Bipolar Disorder (Manic-Depression)
___Schizophrenia	___Intermarriage between relatives
___Genetic syndromes	___Neurological problems

Patient's Initials___

VI. SCHOOL INFORMATION

School:_____School District: _____Grade:_____ Repeated Grades: _____

1. What are your child's current grades? □ Failing □Below Average □Average □Above Average
2. Has there been a change in your child's grades? □ Yes □ No If yes, explain: _____
   _____
3. Is your child's work modified in any way? □ Yes □ No If yes, explain: _____
   _____
4. Has your child been required to attend summer school? □Yes □No If yes, explain: _____
   _____
5. Please mark (✓) your child's WEAKEST academic areas:

___Phonics/Learning Letter Sounds	___Reading Single Words
___Reading Fluency (smoothly)	___Reading Comprehension
___Spelling	___Handwriting
___Written expression	___Copying from the Board
___Learning numbers	___Basic Math Skills (adding, subtracting, multiplying, division)
___Math reasoning (word problems)	___Speech/Language Difficulties

VII. SOCIAL HISTORY

1. Are you concerned about your child's ability to make friends and get along with others?
   ___Yes ___No If yes, explain: _____
2. Does your child have a best friend? □Yes □No
3. Does your child have good eye contact with others? □Yes □No
4. Does your child show interest in other children? □Yes □No

_____ _____ _____

Parent/Guardian Signature Relationship to Child Date

Assessment Scale – Parent Informant

Today

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10 Fidgets with hands or feet or squirms in seat	0	1	2	3
11 Leaves seat when remaining seated is expected	0	1	2	3
12 Runs about or climbs too much when remaining seated is expected	0	1	2	3
13 Has difficulty playing or beginning quiet play activities	0	1	2	3
14 Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15 Talks too much	0	1	2	3
16 Blurts out answers before questions have been completed	0	1	2	3
17 Has difficulty waiting his or her turn	0	1	2	3
18 Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19 Argues with adults	0	1	2	3
20 Loses temper	0	1	2	3
21 Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22 Deliberately annoys people	0	1	2	3
23 Blames others for his or her mistakes or misbehaviors	0	1	2	3
24 Is touchy or easily annoyed by others	0	1	2	3
25 Is angry or resentful	0	1	2	3
26 Is spiteful and wants to get even	0	1	2	3
27 Bullies, threatens, or intimidates others	0	1	2	3
28 Starts physical fights	0	1	2	3
29 Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30 Is truant from school (skips school) without permission	0	1	2	3
31 Is physically cruel to people	0	1	2	3
32 Has stolen things that have value	0	1	2	3

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant, continued

Today's Date: / / Child's Name: _____ Date of Birth: / /

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone elses home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments: _____

SCHOOL QUESTIONNAIRE
To be completed by your child's current teachers

PLEASE COMPLETE IN BLACK INK

CHILD'S NAME: _____ BIRTHDATE:_____/____/_____

SCHOOL: _____ GRADE:_____SCHOOL DISTRICT: _____

ADDRESS:_____CITY/STATE/ZIP: _____

SCHOOL PHONE NUMBER: _____/_____ DATE FORM FILLED OUT:_____/_____/_____

NAME OF PERSON COMPLETING FORM: _____

1. Is this child in a Special Education program?	☐YES ☐NO If yes, explain: _____
2. Does this child receive any interventions?	☐YES ☐NO If yes, explain: _____
3. Does this child receive any classroom modifications?	☐YES ☐NO If yes, explain: _____
4. Does this child have problems with handwriting?	☐YES ☐NO If yes, explain: _____
5. Does this child have problems copying from the board?	☐YES ☐NO If yes, explain: _____
6. Does this child have difficulties making friends?	☐YES ☐NO If yes, explain: _____
7. Does this child have problems making eye contact?	☐YES ☐NO If yes, explain: _____
8. Does this child have problems expressing his/her thoughts?	☐YES ☐NO If yes, explain: _____
9. In your opinion, is this child functioning at capacity?	☐YES ☐NO If yes, explain: _____
10. Have you discussed these problems with his/her parents?	☐YES ☐NO

PLEASE DESCRIBE WHAT CONCERNS YOU MOST ABOUT THIS STUDENT:

PLEASE COMPLETE THE NICHQ VANDERBILT ASSESSMENT SCALE ON THE FOLLOWING (2) PAGES.

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: ____/____/____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

	Symptoms	Never	Occasionally	Often	Very Often
1.	Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2.	Has difficulty sustaining attention to tasks or activities	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7.	Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8.	Is easily distracted by extraneous stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12.	Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13.	Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks excessively	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting in line	0	1	2	3
18.	Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19.	Loses temper	0	1	2	3
20.	Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21.	Is angry or resentful	0	1	2	3
22.	Is spiteful and vindictive	0	1	2	3
23.	Bullies, threatens, or intimidates others	0	1	2	3
24.	Initiates physical fights	0	1	2	3
25.	Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26.	Is physically cruel to people	0	1	2	3
27.	Has stolen items of nontrivial value	0	1	2	3
28.	Deliberately destroys others' property	0	1	2	3
29.	Is fearful, anxious, or worried	0	1	2	3
30.	Is self-conscious or easily embarrassed	0	1	2	3
31.	Is afraid to try new things for fear of making mistakes	0	1	2	3

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: ____/____/____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments: _____

Please return this form to: _____

Mailing address: _____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1 – 9: _____

Total number of questions scored 2 or 3 in questions 10 – 18: _____

Total Symptom Score for questions 1 – 18: _____

Total number of questions scored 2 or 3 in questions 19 – 28: _____

Total number of questions scored 2 or 3 in questions 29 – 35: _____

Total number of questions scored 4 or 5 in questions 36 – 43: _____

Average Performance Score: _____

NICHQ National Initiative for Children's Healthcare Quality

American Academy of Pediatrics

McNeil Consumer & Specialty Pharmaceuticals

FINANCIAL INFORMATION

ALL INFORMATION MUST BE COMPLETED FOR APPLICATION TO BE PROCESSED

*****APPLICATION WILL NOT BE PROCESSED WITHOUT COPY OF INSURANCE CARD*****

PRIMARY INSURANCE

INSURANCE COMPANY:_____ PHONE #: _____
INSURED NAME _____ RELATIONSHIP TO CHILD _____
SS NUMBER OF INSURED _____ DATE OF BIRTH: _____
EMPLOYER NAME _____ PHONE #: _____
STREET ADDRESS OF EMPLOYER _____
CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE OF INSURED _____ DATE: _____
(Required)

SECONDARY INSURANCE

INSURANCE COMPANY: _____ PHONE #: _____
INSURED NAME: _____ DATE OF BIRTH: _____
EMPLOYER NAME: _____ PHONE #: _____
STREET ADDRESS OF EMPLOYER _____
CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE OF INSURED _____ DATE: _____

IF THERE IS NO INSURANCE COVERAGE ON THE CHILD, PLEASE SIGN THE FOLLOWING STATEMENT:

☐ I DO NOT HAVE PRIVATE INSURANCE, MEDICAID OR CHIP:

_____
(Signature of Responsible Party (Parent/Guardian Responsible for Payment)

You have the option to apply for our **SLIDING SCALE FEE PROGRAM.**
This optional program is designed to assist our clients who are unable to pay the full amount for the services they will receive here at the Child Study Center. This program is based on the number of people and the total income of the household. If you would like to apply for this program, you will need to send your tax return for the previous year. Please contact Client Services at 682-303-9300 for further information on this program.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: In consideration for the services to be rendered, I promise to pay for those services in accordance with the rates and terms now in effect at the Child Study Center. I hereby assign to the Child Study Center any and all benefits and all interest and rights (including cause of action and the right to enforce payment) for services rendered under any insurance policies or any reimbursement or prepaid healthcare plan, if applicable. I acknowledge that any balance not covered or paid by such policy or plan is my responsibility. I understand that failure to pay will result in suspension of service.

_____ _____ _____
Signature of Parent/Guardian Responsible for Payment **Social Security Number** **Relationship to Child**

AUTHORIZATION FOR USE & DISCLOSURE (RELEASE) OF PROTECTED HEALTH INFORMATION
(NOTE: All items must be completed to be valid)

This form, if signed, will authorize Child Study Center (CSC) to use and disclose certain health care information about the person's name below. All items must be completed and the authorization signed to be valid. I understand this authorization is voluntary, I may refuse to sign this authorization and I understand that CSC may not withhold treatment because I refuse to sign this authorization.

1. I authorize the Child Study Center to disclose health information, as described below, from the medical record of:

   Patient's Name _____ Date of Birth _____

2. The information specified below may be released to:

   Name: _____

   Address: _____ Telephone: _____

   City: _____ State: _____ Zip: _____

3. The specific purpose(s) for this disclosure is/are (check (✓) your selection(s):
   ( ) My personal records; ( ) Sharing with other health care providers; ( ) Eligibility for services;
   ( ) Sharing with educational professionals
   ( ) Other [please describe] _____

4. ( ) **I WANT** ( ) **DO NOT WANT** (check your preference) the specified information to be released to include history, diagnosis and/or treatment for HIV testing, AIDS, communicable diseases, drugs/alcohol and mental health disease.

5. **SPECIFY EXACT INFORMATION TO BE RELEASED:** (1) Place a check (✓) next to the specific information needed, and (2) List the specific dates of service.

6. I acknowledge the following statements:

	INFORMATION	DATES OF SERVICE *Check here for All Dates* ( )		INFORMATION	DATES OF SERVICE *Check here for All Dates* ( )
	Assessment Report			Session Notes	
	Chart Notes			School Performance Update	
	Discharge Summary			Treatment Plan	
	Notification of Incident			Verbal Communication Notes	
	Patient Plan			Other:	
	Psychiatric Evaluation			Other:	
	Psychological Evaluation			Other:	

- I understand I may revoke this authorization at any time by notifying CSC in writing at ATTN: Child Study Center, Medical Records Department, of my intent to revoke this authorization, except that if I do notify CSC in writing of my intent to revoke this authorization, such revocation will not have any effect on any actions taken before the revocation.
- Unless otherwise revoked, I understand this authorization will expire 365 days from the date this form is signed. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and federal privacy laws or regulations may not protect the information.
- I understand that I may inspect and receive a copy of the information to be disclosed pursuant to this authorization form before I sign this form if I ask to do so. If authorization is requested from CSC, I understand that upon my request, CSC will give me a copy of this authorization form after I sign it.
- I understand I may be charged for any copies of my records or my child's record I request for myself or for use by others. I understand fees for copies may be due and payable before copies are released.
- I understand that I may be asked to show proof that I have the authority to sign authorization to review and/or receive copies of the above named patient's medical records which I am requesting.
- I agree that a facsimile or photocopy of this authorization is as valid as the original.

_____ _____ _____
Date Signature of Patient, Parent, or Legal Guardian Relationship to Patient

_____
Printed Name of Patient, Parent, or Legal Guardian