Intake Checklist

We know you are excited to have your child diagnosed by our world-class diagnostic system. We are too! For a smooth and productive first visit, please bring the following documents with you. To minimize your wait time in our patient lounge, kindly send all documents *one week ahead of your first appointment* to our office:

Bright Minds Institute – San Francisco	**Bright Minds Institute – Vero Beach**
350 Sansome St., Ste. 680 San Francisco, CA 94104 -or- Email: admin@brightmindsgroup.com -or- **Fax: 415-561-6759**	920 37th Place, Ste. 104 Vero Beach, FL 32960 -or- Email: florida@brightmindsgroup.com -or- **Fax: 772-299-4720**

Only a completed **intake packet**, **copies of insurance cards** (USA only) and **prepayment of relevant fees** are required before our medical staff can begin reviewing your child's case and conducting diagnostic tests.

___ 1) Completed Intake Packet, pages 1-11 (REQUIRED)

___ 2) Raw data of any previous EEG on CD plus written report

___ 3) Raw data of any previous MRI on CD plus written report

___ 4) Past Neuropsychological work-up report

___ 5) Latest IEP report

___ 6) Neuro/biofeedback, OT, S/T, P/T, ABA current evaluations

___ 7) Copies of recent blood work (liver/kidney/lead/B12, etc)

___ 8) Therapeutic drug monitoring: medication levels in the blood

___ 9) Any additional valid measurements of the child over the last 3 years

___10) Copies of the front and back of your insurance cards. (REQUIRED)

If you have any questions feel free to contact us during business hours, posted at our website. Kindly reference the ***Frequently Asked Questions*** page on our website also. We look forward to taking care of your family!

Cheers,
BMI Staff

CHILD INFORMATION FORM

Date:_____

Patient's Full Name:	Date of Birth:
Gender: *(Circle)* Male or Female	Diagnosis:
Height & Weight:	Patient's Social Security No.:
Allergies:	Does the patient have any implants, metal parts or pacemakers? *Please Describe*
Mother's / Guardian's Name:	Father's / Guardian's Name:
Mother's / Guardian's Phone Numbers: Home: Cell: Work: Fax: Email:	Father's / Guardian's Phone Numbers: Home: Cell: Work: Fax: Email:
Mother's / Guardian's Address:	Father's / Guardian's Address:
Referring Physician: Phone:	Who to contact in case of emergency: Phone:

**Please present your insurance card at the time of service.*

Insured's Name: _____ Insured's DOB:_____

Name of Insurance Provider: _____

Insured's Social Security No:_____ HMO or PPO? *(Circle one)*

Insured's ID No:_____ Policy Group No: _____

Child History Form

Please provide the following information for your evaluator's review. Thank you.

General Patient Information

Patient Name: _____ Date: _____

Date of Birth: ____/____/____ Age: _____ yrs old Height: _____ Weight: _____ lbs

Who does the patient live with? _____

Mother's Name: _____ Occupation:_____

Father's Name: _____ Occupation:_____

What languages are spoken at home; primary language? _____

_____

_____

If your patient was adopted, please check here: ☐ Yes ☐ No

Pregnancy History

Please describe the patient's birth history:

Length of: Pregnancy: _____mos. Hospital stay:_____

Labor:_____

Type of Delivery (check one): ☐ Vaginal ☐ Forceps ☐ Cesarean ☐ Breach

Difficulty of Labor: ☐ Easy ☐ Moderately Difficult ☐ Very Difficult

Patient's weight at Birth: _____lbs _____oz. Apgar Scores: _____, _____

Please describe any complications during pregnancy or delivery (for example: prolonged hospitalization, intubation, any special care or treatment the baby was given, etc.):

_____

_____

_____

_____

Developmental History

Overall, was the patient's development: ☐Early ☐Average ☐ Late

At what age did the patient first meet the following developmental milestones:

Sit: ____ Crawl: ____ Walk: ____ Potty training: ____ (☐ Easy ☐ Difficult)

Babble: ____ First Word: ____ (What was it?_____)

As an infant, did the patient have difficulty feeding or sleeping? ☐Yes ☐No

If so, please describe: _____

_____

_____

As an infant/ toddler, has the patient experienced poor muscle control (ex: weakness or clumsiness) in the following: (*check all that apply*)

☐Neck ☐Trunk ☐Legs ☐Arms

As an infant/toddler, were the patient's muscles seem to be unusually tight or stiff?

☐Yes ☐No If yes, please describe: _____

_____

_____

_____

As an infant/toddler, the patient was: (*please check all that apply*)

☐Calm ☐Inactive ☐Active ☐Irritable ☐Over-reactive

How is the patient disciplined at home? _____

_____

_____

_____

Describe the patient's temperament/personality (i.e., how he/she handles frustration, his/her response to affection, needs, what motivates him/her): _____

_____

_____

_____

General Medical History

Does the patient have speech or language problems? ☐Yes ☐No ☐Unsure

Does the patient have fine motor/handwriting problems? ☐Yes ☐No ☐Unsure

Does the patient have gross motor/ coordination problems? ☐Yes ☐No ☐Unsure

To the best of your knowledge, does the patient have limitations in the following? Also please provide the most recent exam dates and results:

☐Hearing:_____

☐Vision: _____

Does the patient wear any corrective lenses or use any hearing aides? ☐Yes ☐No

** If yes, please be sure to bring them to all appointments at Bright Minds Institute.*

Does the patient have any known allergies? ☐Yes ☐No

If so, please describe: _____

_____

_____

Has the patient had an MRI or an EEG? ☐Yes ☐No If so, when? _____

Please describe the patient's medical history (including any major illnesses, surgeries, hospitalizations, seizure activity, etc.): _____

_____

_____

_____

_____

Has the patient been given any diagnoses? ☐Yes ☐No

If so, please describe: _____

_____

_____

_____

Is the patient currently on any medication? ☐Yes ☐No

If yes, please list: (please include any past medications, dosages, frequencies, and any positive or negative effects it had.)

	Medication:	Dosages:	Frequencies:	When:
1.)	_____	_____	_____	_____
2.)	_____	_____	_____	_____
3.)	_____	_____	_____	_____
4.)	_____	_____	_____	_____
5.)	_____	_____	_____	_____

Please indicate any feeding concerns (i.e., special diets, g-tube, etc.): _____

_____

_____

_____

_____

Education and Services Information

Name of school patient attends: _____

Address: _____

_____

Teacher's Name: _____ Type of Class: _____ Grade: _____

Contact Person and Phone: _____

Describe any school-based services (i.e., physical therapy, speech therapy, etc.): _____

_____

_____

_____

_____

Describe any private services or weekly activities the patient receives or has received in the past.

	Type of Service	Times Per Week	Goals	Patient's Response
1.)	_____	_____	_____	_____
2.)	_____	_____	_____	_____
3.)	_____	_____	_____	_____
4.)	_____	_____	_____	_____

Describe the patient's academic skills (i.e., grades, strengths/weaknesses, reading and writing ability, any change over the years): _____

_____

_____

_____

_____

_____

Questions and Concerns

Briefly describe the problems you've observed: _____

_____

_____

_____

What specific questions would you like answered:

1.) _____

2.) _____

3.) _____

Please feel free to provide any additional information that you may feel is relevant. What are you hoping to learn from this evaluation?

_____

_____

_____

_____

Any information you have provided will help us help you better. Thank you for taking the time to fill out this form!

OPTIONAL – please fill out only if needed.

Child Authorization for RECEIPT of information

I hereby request and authorize the below-mentioned organization to release to *Bright Minds Institute* any relevant notes, records and / or medical reports or information pertaining to:

Patient's Name:	DOB:	Date:

The organization (hospital, therapist, school, law firm, etc) listed below MAY RELEASE INFORMATION TO Bright Minds Institute:

Organization:	
Attention:	
Address:	
City, State, Zip:	
Phone No. & Fax No.	
Please Specify Records Needed:	

Parent /Guardian Signature: _____

Print Name: _____

Relationship to Patient: _____

Contact Number(s): _____

OPTIONAL – please fill out only if needed.

Child Authorization for RELEASE of information

I hereby request and authorize *Bright Minds Institute* to release any relevant notes, records and / or medical reports or information pertaining to:

Patient's Name:	DOB:	Date:

Bright Minds Institute MAY RELEASE INFORMATION TO

Organization:	
Attention:	
Address:	
City, State, Zip, Country:	
Phone No. & Fax No.	
Please Specify Records Needed:	

Parent / Guardian Signature: _____

Print Name: _____

Relationship to Patient: _____

Contact Number(s): _____

RIGHT TO REFUSE SERVICE
BMI reserves the right to refuse service to any patient on the account of any delinquent or unpaid fees for services performed without any liability or further obligation to the undersigned.

INSURANCE
THE UNDERSIGNED ACKNOWLEDGES AND AGREES THAT BMI DOES NOT PARTICIPATE WITH ANY INSURANCE PROGRAM (UNLESS OTHERWISE SPECIFIED BY THE PROVIDER), AND THAT THE UNDERSIGNED IS SOLELY AND DIRECTLY RESPONSIBLE FOR THE FULL PAYMENT OF ALL FEES CHARGED BY BMI, REGARDLESS OF ANY INSURANCE COVERAGE AFFORDED TO THE UNDERSIGNED. THE UNDERSIGNED ACKNOWLEDGES THAT HE/SHE HAS REVIEWED AND UNDERSTOOD THE FEE SCHEDULE AND INSURANCE REIMBURSEMENT INFORMATION DOCUMENT PROVIDED.

BMI CANCELLATION POLICY
Bright Minds Institute requires 24-hours notice for canceling or rescheduling appointment to avoid incurring any fees. Any appointment that is not rescheduled or cancelled at least 24 hours in advance will be billed at 50% of the total session cost for that date of service.

Our voicemail system (equipped with time/date of message), rescheduling through our website, or simply sending an email to admin@brightmindsgroup.com may be used for rescheduling/cancellation. Please consider rescheduling your child's appointment if your child has a fever or any other bacterial/viral infection.

ENFORCEMENT
The undersigned acknowledges and agrees to reimburse BMI for fees and expenses including, without limitation, any attorney's fees and expenses, incurred by BMI in enforcing any terms or provisions hereof, including, without limitation, the collection of fees for services provided.

THE UNDERSIGNED UNDERSTANDS AND AGREES TO BE BOUND BY THE FOREGOING AND IS MEMORIALIZING SUCHA AGREEMENT BY PROVIDING THE APPROPRIATE SIGNATURE IN THE SPACE BELOW:

SIGNATURE:_____

PRINT NAME:_____

CHILD'S NAME:_____

DATE:_____

Patient Services Acknowledgement and Agreement

Patient Name: _____ Date:_____

By providing his/her signature in the space below, the undersigned agrees to accept the therapy services provided by the Bright Minds Institute (BMI) in accordance with and pursuant to the following terms and conditions:

FEES

All fees pertaining to evaluation, diagnosis and treatment services performed by the Bright Minds institute shall be payable at time of service. You will receive an invoice to submit to your insurance for reimbursement each time we charge your card. Intake and Record Review Fees will be billed prior to your Clinical Evaluation (first appointment). For our signature BEAM/DEEP Assessment, a deposit will be collected 2 weeks prior to the first day of treatment in the amount of 25% of total session fees with the remaining balance collected upon the first day that treatment is rendered.

ANY AND ALL FEES CHARGED BY BMI ARE SUBJECT TO CHANGE AT THE SOLE DISCRETION OF BMI UPON PRIOR NOTICE TO THE UNDERSIGNED.

The undersigned hereby authorizes BMI to charge my credit card (information is provided below) the amount of any balance remaining outstanding more than 30 days after issuance of an invoice.

Credit card to be charged:

Type of Card: MasterCard Visa American Express CareCredit _____

Name as it appears on Card : _____

Relationship to Patient : _____

Card Number : _____

Expiration Date : _____/_____

Billing Address : _____

_____

Security Code (on front or back of card) : _____

Signature of Cardholder : _____

By signing this agreement the cardholder gives Bright Minds Institute permission to hold this credit card on file to be charged for all medical services provided.