Child and Adolescent Health Specialists, PC

About Developmental-Behavioral Pediatrics

Thank you for your interest in Developmental-Behavioral Pediatric Services at Child and Adolescent Health Specialists, PC. Dr. Belknap has many years of experience specializing in diagnosing and treating children with autism spectrum disorders, problems of attention/learning, developmental delay and behavior problems associated with these issues. He is certified as a diplomate in Developmental-Behavioral Pediatrics by the American Board of Pediatrics.
Dr. Belknap is on the teaching faculty at Tufts University School of Medicine.

For additional information, see our website: www.drbelknap.com

Insurance/Billing/Referrals

Our office will submit claims for Developmental-Behavioral appointments to the following insurances:
Blue Cross and Blue Shield, Harvard Pilgrim, Tufts, United, Fallon and Tricare

If your child is covered by any other insurance, we recommend that you call the insurance company to verify whether they will reimburse for these services as "out of network." You will be required to pay the full amount at the time of the appointment. We will give you a receipt with the appropriate codes to submit to your insurance company for reimbursement.

If your insurance is an **HMO**, you will need to obtain a referral from your primary care doctor (PCP). If you wish to be placed on our cancellation list, you may request that your doctor date the referral effective the day you call for it rather than the date of the appointment. Otherwise, in the event that your appointment is moved to an earlier time, your primary care doctor would need to correct the referral for the new date. Referrals are good for 1 year from date issued. **If you do not have a referral on the date of your appointment you will be required to pay for the visit in full.** You may submit to your insurance company for reimbursement.

To bill any insurance company for a consultation appointment, a request from a professional is required. If you have an HMO, the referral from your child's PCP will serve as this request.

If your insurance is a **PPO**, we will need a written request for a consultation from the referring provider, whether this is your PCP, a therapist, teacher, etc. Please have the enclosed **Request for Consultation** form completed by your referring professional.

Scheduling Appointments

To schedule an appointment, complete and return the enclosed registration packet as soon as possible. We will review your information to determine the appropriate type and time for your appointment(s). Following review, our office will contact you to schedule your appointment(s).

Outside Testing/Reports

You may send copies of any relevant information to our office prior to your visit or you may bring them on the day of your appointment. Please bring copies not originals. Our office will not be able to copy them for you and we will not be responsible for loss of the originals. If you wish to have copies of any materials that Dr. Belknap sends home for completion (eg. ANSER questionnaires), please copy them **prior** to returning them to the office. We will not be able to copy them for you and originals must be kept as part of our medical records.

The First Consultation Visit

We recommend that children other than the one who is being seen at the appointment not accompany you to the appointment as this can be a significant distraction. Children must be over 8 years of age to remain in the reception room without adult supervision. Please set aside approximately 2 hours for your initial consultation appointment.

All efforts are made to make your child's experience comfortable. A nurse will obtain measurements, vital signs, an evoked otoacoustic hearing evaluation, and a vision screening (3 years of age or greater).

Following your consultation appointment, a summary letter will be sent to the referring physician or other professional with a copy to the parents.

Please be aware that additional reports (eg. letters to schools) are typically not covered by health insurance plans. Such requests will require payment in advance.

Neurodevelopmental Testing Appointments

Dr. Belknap may schedule your child for neurodevelopmental testing following your consultation. Please set aside approximately 1½ hours for this appointment. *Note this is not the same testing provided by schools for a CORE evaluation.

Please feel free to call our office if you have any additional questions or concerns.

*The following forms should be filled out with black or blue ink as other colors will not show through fax or scanner

Child and Adolescent Health Specialists, PC

PATIENT REGISTRATION FORM

DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
Robert F. Belknap, MD, MPH, FAAP

Child's First Middle Last Name		Date of Birth	Age	Sex
Street Address	City	State	Zip	
Preferred Phone # (for office to contact you)	How did you hear about us? ❑ Physician ❑ Family/Friend ❑ Mailing ❑ Newspaper ❑ Internet ❑ Other _________			
Mother's Name	Father's Name		Parent's Marital Status S M D W	
Legal Guardian (if different from above) – If other than parent, you must provide legal documentation				
Parent/Guardian Street Address (if different from above)	City	State	Zip	
Parent/Guardian Home Phone #	Cell Phone #	Work Phone #	E-mail Address	
Next of Kin/Emergency Contact Name		Relationship	Telephone #	

PRIMARY INSURANCE COMPANY – EFFECTIVE DATE ___________

Name of Insurance Company		Policy ID #	Group #
Street Address	City	State	Zip
Name of Policy Holder	SS #	Date of Birth	Relationship to Insured
Employer Name and Address			

SECONDARY INSURANCE COMPANY – EFFECTIVE DATE ___________

Name of Insurance Company		Policy ID #	Group #
Street Address	City	State	Zip
Name of Policy Holder	SS #	Date of Birth	Relationship to Insured
Employer Name and Address			

ASSIGNMENT OF BENEFITS

I understand that I am responsible for payment in full of all charges. I request that payment of authorized Medicare and other insurance benefits be paid directly to Child and Adolescent Health Specialists, PC. I also authorize Child and Adolescent Health Specialists, PC to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine the benefits payable for related services.

Signature ____ Date _________________________

Child and Adolescent Health Specialists, PC

PATIENT HISTORY FORM

DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
Robert F. Belknap, MD, MPH, FAAP

Child's Name: ____ DOB: ____________

Your Name: ______________________________ Relation to child: ________________

Child lives with: ___________________ Relation to Child: ________ DOB:__________

Referred by: ____

Any Previous Evaluations / Testing? Yes No If yes,

Where: __________________ Performed by:____________________________________

When: ___________________

Current or Previous Diagnoses: ____

Name of School / Daycare: ____

Address:____

Is your child currently on an IEP or 504 plan? Yes No

Date of last CORE evaluation: ____________________

How would you rate your child's school performance at this time?

____ Good ____ Fair ____ Poor

Child's Primary Care Physician:____

Address: ____

Telephone: ___________________

Current Medication(s): _____________________ Dose ___________

_____________________ Dose ___________

_____________________ Dose ___________

Name of doctor who is currently managing medications: _________________________

Please list previous medications and reason for discontinuing:

____

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PATIENT HISTORY FORM (continued)

DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
Robert F. Belknap, MD, MPH, FAAP

Is your child currently receiving or has he/she in the past received any services or therapies? (i.e. Speech, Occupational, Physical Therapies, ABA, other)
Please include dates, where performed, and frequency.

____

____

____

Is your child followed by any other Specialists? Yes No If so, by whom:

____

____

Family History (include grandparents, aunts & uncles)

- ☐ School Problems
- ☐ Attention Disorders
- ☐ Depression
- ☐ Suicide Attempts
- ☐ Anxiety Disorders
- ☐ Hereditary deafness or blindness
- ☐ Panic Attacks
- ☐ Autism/Asperger's Syndrome
- ☐ Mental Retardation
- ☐ Alcoholism
- ☐ Substance Abuse
- ☐ Genetic Disorders
- ☐ Seizures/Epilepsy

Any other problems of development:__________

____

____

____

What specific questions or concerns do you wish to be addressed?

____

____

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223 Chief Justice Cushing Highway, Suite 201, Cohasset, MA 02025 ◆ T. 781.383.8380 ◆ F. 781.930.1791 ◆ www.drbelknap.com

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Please Note: A parent or legal guardian must accompany any minor child to a developmental-behavioral pediatric appointment.

NOTICE OF PRIVACY PRACTICES

DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
Robert F. Belknap, MD, MPH, FAAP

HIPAA PRIVACY PRACTICES

A. We have a legal duty to protect health information about you.

B. We may use and disclose Protected Health Information or “PHI” about you in the following circumstances:

1. We may use and disclose PHI about you to provide health care treatment to you.
2. We may use and disclose PHI about you to obtain payment for services.
3. We may use and disclose your PHI for health care operations.
4. We may use and disclose PHI under other circumstances without your authorization, such as when required by law or for public health activities.
5. You can object to certain uses and disclosures.
6. We may contact you to provide appointment reminders.
7. We may contact you with information about treatment, services, products or health care providers.
8. We may contact you for fundraising activities.

Any other use or disclosure of PHI about you requires your written authorization.

C. You have several rights regarding PHI about you.

1. You have the right to request restrictions on uses and disclosures of PHI about you.
2. You have the right to request different ways to communicate with you.
3. You have the right to see and copy PHI about you.
4. You have the right to request amendment of PHI about you.
5. You have the right to a listing of disclosures we have made.
6. You have a right to a copy of this notice.

D. You may file a complaint about our privacy practices.

E. For additional information regarding privacy practices, contact the Office Manager.

This Notice of Privacy Practices is effective as of today’s date: ______________________

Patient’s Name: ____

Parent/Guardian Signature: ____

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CANCELLATION POLICY

DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
Robert F. Belknap, MD, MPH, FAAP

Due to the considerable time allotted in the schedule for developmental-behavioral problems, Developmental–Behavioral Consultation appointments and Neurodevelopmental Testing appointments that are not kept or cancelled with less than **7 days** notice **FOR ANY REASON** will result in a charge of $300.00.

All subsequent appointments not kept or cancelled with less than **48** hours notice will incur a $150 charge.

Calls for cancellations must be received during regular business hours. Calls will not be accepted by the after hours emergency answering service for cancellations.
Monday appointments must be cancelled by 5pm the preceding Friday.

A credit card number or deposit of $300.00 is required to which we will bill these charges if incurred.

All forms must be filled out completely and signed in order to schedule your appointment.

CHILD'S NAME: ______________________________ **DATE OF BIRTH:** _______________

PARENT'S SIGNATURE: ___________________________________ **Date**:_______________

Credit Card to reserve your appointment time: A preauthorization will be processed through your credit card prior to your appointment(s).

Type: (circle one) MasterCard or Visa

Name on Card: ____

Credit Card #: ____

Expiration Date: ____

CV # (3 letter code on back): ____

* ***We cannot schedule your appointment until we have received all 7 pages***

Upon receipt of **all 7 pages** our office staff will contact you to schedule your appointment.

Revised as of 5/01/09

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Insurance and Billing Information:

Our office will submit claims for Developmental-Behavioral appointments to the following insurances:

Blue Cross and Blue Shield, Harvard Pilgrim, Tufts (includes Carelink), United, Fallon and Tricare

The following is a list of our most commonly applied insurance codes for Developmental-Behavioral Appointments. Codes are based on the type and duration of appointment scheduled. Our fees are based on industry standard rates and are competitive with other practices similar in scope and nature. Please note this is not an inclusive list. Reimbursement for any code is at the discretion of each individual insurance carrier, and can vary within plans based on employer choice. We do not know what each individual plan will cover. If you have any questions or concerns, please contact your insurance provider prior to scheduling your appointment (s).

Developmental Behavioral Pediatrics Codes:
Developmental-Behavioral Consultation, new patient (99245,99244)
Otoacoustics Emissions hearing test, diagnostic (92588)
Vision screening (99173)

Developmental Testing (96110, 96111, 96116)
Interpretation/Administration of Health/Risk assessment (99420)
Review of Medical records – Pro-rated based on hourly rate (99358)
Prolonged visit code (99354)
Evaluation and Management of new patient (99205, 99204, 99203, 99202)
Evaluation and Management of established patient (99215, 99214, 99213, 99212)
Telephone calls/consultations (99441, 99442, 99443)
Special/additional reports eg. insurance appeals, school letters (99080)

Please be aware that requests for telephone consultations and **additional** reports (eg. letters to schools) will not be covered by your insurance and will require payment in advance.

This list is representative and not inclusive. I understand that these or other applicable codes may not be covered by my insurance and I am responsible for payment in full if not.
Services denied by your insurance or determined to be patient responsibility will be charged to your credit card listed on previous page.

Child's Name: _________________________________

Parent/Guardian Signature: ____

Date: _____________________

Child and Adolescent Health Specialists, PC

REQUEST FOR CONSULTATION
(This form applies ONLY if your INSURANCE is a PPO)

To bill any insurance company for a consultation appointment, a request from a professional in a related field is required.

If your insurance is an HMO, the referral from your child's PCP will serve as this request and this form does not need to be completed.

If your insurance is a PPO, please have this **Request for Consultation** form completed by your **referring professional** (eg. your PCP, a therapist, teacher, etc.).

To: Robert F. Belknap, MD, MPH

From: (professional requesting consultation) ____________________________________

Address: ____

Phone: ________________________________ Fax: ______________________________

Date:
Patient:
DOB:
Reason for consultation:
Pertinent history: Signature of requesting provider: ____

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