Lake Norman Pediatric Therapy
Danielle Farese Milburn, Ph.D.
Villages at Harborside 8210 Village Harbor Drive Cornelius NC, 28031
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Welcome Packet

Please review our *Welcome Letter* and sign the last page. Please detach the signature page to bring with you to the initial consultation.

The *Release of Information* is included, should we need it for any reason. Please keep this with your files.

Complete our *Developmental Questionnaire* to bring with you to the initial consultation.

A map has also been included for your convenience. Please review to ensure the directions are clear. If you have any questions or concerns, please call my assistant at 704-895-6379.

Thank you for the opportunity to work with you and your family. If at any time you need to speak with me directly, you may call 704-728-9672.

Danielle Farese Milburn, Ph.D.

Welcome to my practice.

I appreciate your giving me the opportunity to be of help to you and your family.

This brochure talks about the following in a general way:

- Patient Testing and Treatment
- Goals of Testing and Treatment
- Cost of Services and Payment Options

After you read this brochure, we can discuss how these issues apply to your own situation. This brochure is yours to keep and refer to later. Please read all of it and mark any parts that are not clear to you. Write down any questions you think of, and we will discuss them at our initial meeting. When you fully understand this brochure, please sign the signature page and return to our office.

Because you will be putting a good deal of time and energy into your child's care, you should choose a psychologist carefully. I strongly believe you should feel comfortable with the psychologist you choose, and hopeful about the treatment strategy. When you feel this way, your family's treatment is more likely to be very helpful to you and your child.

I think of my approach to helping children, adolescents, and their families with their concerns as an educational one. Regarding behavioral and/or emotional challenges, I combine two types of treatment called "Cognitive Behavioral Therapy and Parent-Child Interaction Therapy." My goal is to help promote positive social development in children through young adulthood. Social skills development, cognitive-behavioral coping stategies, behavior management, and parenting techniques are an important part of an individual's development. Therefore, parents, children, adolescents, and young adults are provided the skills necessary to understand, prevent, cope with, and solve behavioral, social, emotional, and/or academic challenges.

When conducting assessments, I strive to provide comprehensive neuropsychological, and/or psychoeducational evaluations that are tailored to meet the needs of each client. I combine my school system knowledge with my clinical neuropsychological training to provide families with a highly detailed, yet "user friendly" learning analysis. Strategies are provided that are linked to that specific assessment data. Essentially, my goal is for each assessment to serve as a "road map" that guides subsequent services, academic supports, coping skills, interventions, etc. that allow individuals to overcome their respective learning challenges.

Confidentiality

Psychological services are best provided in an atmosphere of trust. You expect me to be honest with you about your problems and progress. I expect you to be honest with me about your expectations for services, your compliance with medication, and any other barriers to treatment.

I will treat any information you share with me with the strictest confidentiality. It is your legal right that our sessions and my records about you are kept private. That is why I ask you to sign a "release of records" form before I can talk about you or send my records about you to anyone else. In general, I cannot reveal that you are receiving treatment from me.

In all but a few rare situations, your privacy is protected by state law and by the rules of my profession. Here are the most common cases in which confidentiality is not protected:

1. If you were sent to me by a court for evaluation or treatment, the court expects a report from me. If this is your situation, please talk with me before you tell me anything you do not want the court to know. You have a right to tell me only what you are comfortable with telling me.

2. Are you suing someone or being sued? Are you being charged with a crime? If so, and you tell the court you are seeing me, I may then be ordered to show the court my records. Please consult your lawyer about these issues.

3. If you make a serious threat to harm yourself or another person, the law requires me to try to protect you or the other person. This usually means telling others about the threat. I cannot promise never to tell others about threats you make.

4. If I believe that a child has been or will be abused or neglected, I am legally required to report this to the authorities.

"As a psychologist, my legal and moral duty is to protect confidentiality, but I also have a duty under the law to the wider community and to myself, if there is harm, threat of harm, or neglect."

Scheduling and Payments

The following information should answer any questions you might have regarding the scheduling of appointments or payment for professional services provided.

Scheduling:

Office hours: Monday - Friday: 9:00 A.M. to 5:00 P.M.

- You are requested to give this office notice of cancellation. No less than 24 hours is expected. If notice is not given, there will be a "no show" fee of $100.00. Consideration will, of course, be given if an emergency arises.

- Please arrive on time for your appointment. While we try to allocate additional time in our schedule in anticipation of emergency delays, we want to provide each patient the same amount of service and care while testing. Due to the heavy volume of testing, we have a **late arrival** policy. Patients arriving 10+ minutes late to their appointment may need to be rescheduled. Dr. Milburn will decide if there is enough remaining time for testing in the allotted appointment time. Because of the nature of the evaluations, other patients' appointments cannot be moved.

- If you are unfamiliar with the location of our office, please map out your route before your appointment. You may even want to physically make the drive ahead of time to ensure you are able to find it easily. Please consult the map and driving directions in this packet.

- In the event of inclement weather, our office follows the guidelines set forth by Charlotte Mecklenburg School System. If they have canceled all classes, our office will be closed. You will be contacted by someone in our office to reschedule your appointment. We will do everything possible to keep your appointment on a timely schedule.

What Should I bring To My Child's Testing Appointment:

- If your child will be seen in our office for testing, please bring a snack & drink.
- Please bring any past testing/assessment results, report cards or any other written documentation that you feel will be beneficial in the diagnostic process for your child, to the Initial consultation.

Therapy sessions are based on a "60 minute hour." Each session begins on the hour.

Fees, Payments, and Billing:

Payment for services is important in any professional relationship. This is even truer in therapy. One treatment goal is to make relationships and the duties they involve clear. You are responsible for seeing that these services are paid for. Meeting this responsibility shows your commitment.

My regular fees are as follows. You will be given advance notice if my fees should change.

***Regular therapy services**:*
Initial Consultation: 60 Minute Session - $250.00 **(Insurance Code 90791)**
Therapy Sessions: 60 Minute Session - $150.00 **(Insurance Code 90837)**

NEUROPSYCHOLOGICAL TESTING SERVICES:

We provide complete neuropsychological testing services for children and young adults ages 5 through college. A comprehensive neuropsychological evaluation of a child or adolescent typically includes the following:

- Initial interview with parents or guardian
- Administration of a complete battery (4-6 hours) of psychological tests
- A feedback appointment to review the results of the tests
- A detailed written report

Neuropsychological Evaluation Services:
$2,350.00 - $2,850.00
(Insurance Codes 96130, 96131, 96136, 96137)

IQ TESTING FOR AREA SCHOOLS:

Metrolina Regional Scholars Academy: 60 Minute Testing Session and Written Report - Starting at $350.00
Early Kindergarten Testing: 60 Minute Testing session and Written Report - $350.00
Homeschool End of Year Testing – Testing and Written Report (price determined by age and grade)

OTHER SERVICES:

Parent Consultations: 60 minutes - $250.00
Administrative Fees: $25.00 -$125.00*

**A fee will be charged for each form, letter or document beyond the initial comprehensive report. Fee will be determined by the length and complexity of the form.*

NOTES:

- *Please make all checks payable to: Danielle Farese Milburn, Ph.D.*
- *Other forms of payment accepted are VISA, MasterCard, and Discover*
- *Dr. Milburn is OUT OF NETWORK and does NOT file insurance; however, our office gladly accepts FSA and HSA cards*
- *If there is any problem with billing, please call our office. Such problems can interfere greatly with our work. They must be worked out openly and quickly.*
- *If you think you may have trouble paying your bills on time, please discuss this with me so we can arrive at a solution.*
- *Payments on fees left outstanding beyond three months of service will result in the assignment of an interest charge of 1.5% per month (18% per annum).*

Health Insurance Coverage and Payments:

Because I am a licensed psychologist, many health insurance plans will help you pay for therapy and other services I offer. These plans include Blue Shield and most Major Medical plans. Because health insurance is written by many different companies, I cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Behavioral Health." Or call your insurer's office to find out what you need to know.
If your health insurance pays part of my fee, I will help you with your insurance claim forms. However, please keep three things in mind:

1. You are responsible for checking your insurance coverage, deductibles, payment rates, etc. Your insurance contract is between you and your company; it is not between me and the insurance company. If pre-approval for services is a requirement through your insurance company, we will help you with this process. Please let us know before the beginning of testing so that we may start this process.

2. You—not your insurance company or any other person or company—are responsible for all payments.

3. I am currently ***not*** participating in *preferred provider organizations (PPOs), HMOs, or managed care panels;* therefore, your coverage will fall under an "***out of network***" claim.

☑ To seek payment from your insurance company, you must first obtain a claim form from your employer's benefits office or call your insurance company. Complete the claim form. Then attach my statement to the claim form and mail it to your insurance company. My statement already provides the information asked for on the claim form.

I have read and understood the above information:

_____
Client's Signature

_____
Date

Danielle Farese Milburn, Ph.D.
Villages at Harborside:
8210 Village Harbor Drive
Cornelius, NC 28031
Phone: (704)895-6379
Fax: (704)895-6380
E-mail: danielle_milburn@bellsouth.net

AUTHORIZATION TO DISCLOSE INFORMATION

Patient:
Last Name: _____ First Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____

Information Disclosed FROM:

Danielle Farese Milburn, Ph.D.

8210 Village Harbor Drive

Cornelius, NC 28031

Information Disclosed TO: (Attach list if needed)

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Information to be Disclosed:
I understand that my name, date of birth, address, age, gender, phone number, and other demographic and insurance information will be included in any release of health or billing information.

☐ Psychological ☐ Educational ☐ Diagnostic ☐ Progress/Office Notes
☐ Psychiatric ☐ Consultation ☐ Personal History ☐ Treatment
☐ Other (Specify): _____

Method of Disclosure:
☐ In-person ☐ Paper copies picked up ☐ Paper copies mailed ☐Other (Including Fax)

Why is this information being disclosed?
☐ Continuing Treatment ☐ Insurance ☐ Legal Investigation
☐ At the Request of Patient ☐ Other (Specify): _____

Important Information for Patient/Patient Representative:

1. I understand that the person or organization that gets the information may not be a healthcare provider or health plan covered by federal privacy rules. This person or organization may also disclose the information that I have asked to be released. If this occurs I may no longer have any privacy protection.
2. I understand that I may refuse to sign this authorization. My refusal to sign will not change my ability to get treatment, payment for treatment or eligibility for benefits. I may inspect or copy any information that has been either used or disclosed under this authorization.
3. I understand that I have the right to change my mind. I may revoke this authorization at any time by submitting a written request to the Director of the facility where I am sending the Authorization. I understand that I cannot revoke my authorization to the extent Dr. Milburn's office has relied upon it.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT.

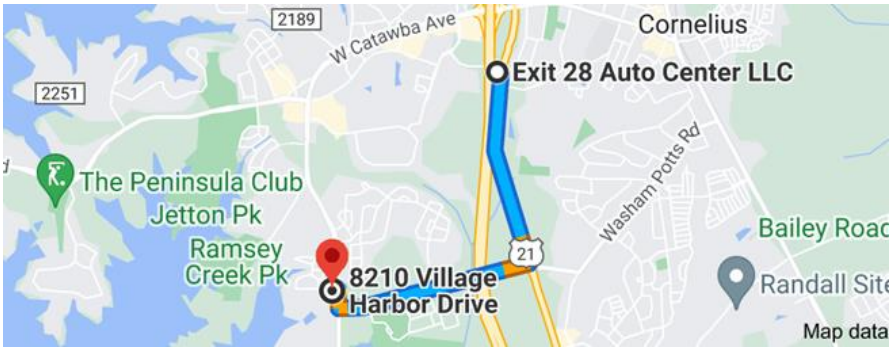
Signature of Patient/Patient Representative: _____ Date: _____
THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE OF SIGNATURE.

Legal Authority is: ☐ Parent of Minor ☐ Guardian ☐ Attorney in Fact
Patient is: ☐ Minor

Health Information Released by: Danielle Farese Milburn, Ph.D. Date: _____

The office of Danielle Farese Milburn, Ph.D. is conveniently located off I-77, Exit 28, West Catawba Ave. If you have any trouble finding our new location, please call our office at (704) 895-6379.

Villages at Harborside
8210 Village Harbor Drive (2nd Floor)
Cornelius, NC 28031



DRIVING DIRECTIONS

- Take I-77 North to Exit 28
- Turn Left Off Exit onto W. Catawba Rd
- Turn Right onto Village Harbor Drive.
- Dr. Milburn's Office is in the First Unit on the left on the **2nd Floor**.
- There is some parking on the street as well as a parking lot behind the building.

We are about 1.5 miles from our old office

PLEASE USE STAIRS OR ELEVATOR

DEVELOPMENTAL QUESTIONNAIRE

Please provide the following information about your child. This information will be used in strict confidence to assist in evaluating and/or treating your child. Thank you

GENERAL INFORMATION:

CHILD'S NAME:	DATE OF BIRTH:	AGE (Year & Month):	SEX:
LIVING WITH:		PHONE:	
ADDRESS:	CITY:	STATE, ZIP CODE	
PEDIATRICIAN/ FAMILY PHYSICIAN:			

FAMILY HISTORY:

	Fathers Name	Mother's Name
Natural-Foster-Adoptive-Stepparent:	_____	_____
Age:	_____	_____
Occupation:	_____	_____
Place of Employment:	_____	_____
Last School Grade Completed:	_____	_____
Date of Present Marriage:	_____	_____
Date(s) of prior marriage:	_____	_____
Date(s) when terminated:	_____	_____

Has there been a history of learning difficulties:

(Please Circle yes or no)

Mother: YES NO If YES, Please Describe: _____

Father: YES NO If YES, Please Describe: _____

Have any of the child's blood relatives experienced any of the following? If yes, what is their relationship to the child?

Please circle yes or no

Learning Difficulties (Reading, Writing, Math)	YES NO	If YES_____
Attention Deficit Disorder (ADD-with or without hyperactivity)	YES NO	If YES_____
Emotional Problems	YES NO	If YES_____
Seizures	YES NO	If YES_____
Other psychiatric illnesses (Depression, Manic Depression,	YES NO	If YES_____
Schizophrenic, Autism, Mental Retardation	YES NO	If YES_____
Alcoholism/Drug Addiction	YES NO	If YES _____

List brothers and sisters of the child:

NAME:	AGE:	SEX:	GRADE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do any other people live in your home? YES_____ NO _____ If YES, who? _____

DEVELOPMENTAL HISTORY:

PRENATAL

Was prenatal care provided? YES _____ NO _____ If YES, at what month of pregnancy? _____

Was medication, alcohol, drugs, and/or tobacco used during pregnancy? YES _____ NO _____
If YES, please explain: _____
If YES, please state what was used: _____
How much: _____ How long: _____

Any infections? YES _____ NO _____ If YES, please explain: _____

PREGNANCY

☐ Full Term (40 Weeks) ☐ Premature: How early? _____ ☐ Late: How late? _____

DELIVERY *(Please Circle and/or provide information where applicable)*

Labor:	Natural	Induced	Duration (Hours) _____
Type:	Vertex (Normal)	Breech	Caesarean
Forceps:	High	Mid	Low
Birth Weight:	_____lbs. _____oz.		
Other Information			

_____

COMPLICATIONS *(Please Check and/or provide information if necessary)*

At Birth: ☐ Cord Around Neck ☐ Hemorrhage (Excessive Bleeding)
☐ Cord Presented First ☐ Infant Injured During Delivery

Other:_____

After delivery:	☐ Intensive Care	☐ Jaundice	Duration (Hours) _____
☐ Infection	☐ Transfusion	☐ Oxygen Used	☐ Cyanosis (Turned Blue)

Other:_____

DEVELOPMENTAL MILESTONES: *(Please provide the age that your child achieved each milestone)*

Smiled:	_____	Spoke First Words:	_____
Crawled:	_____	Said First Sentence:	_____
Stood (without support):	_____	Bowel Trained:	_____
Walked (without assistance):	_____	Bladder Trained:	_____

MEDICAL HISTORY:

If your child's medical history includes any of the following, please note the age, the incident or illness that occurred, and any other pertinent information.

	Age	*Incident/Illness*	*Other Information*
Childhood Illness	____	_____	_____
Hospitalizations	____	_____	_____
Head Injuries	____	_____	_____
Loss of Consciousness	____	_____	_____
Seizures	____	_____	_____
Hearing Problems	____	_____	_____
Persistent High Fevers	____	_____	_____
Ear Infections	____	_____	_____
Allergies	____	_____	_____
Medications	____	_____	_____

Has your child had previous testing done? _____

If **yes**, *what tests were taken and when* _____
_____

SCHOOL HISTORY:

Current School: _____Grade: _____

Has your child repeated any grade(s)? ☐ YES ☐ NO, If **yes**, which one(s)? _____

Do your child's grades in school vary dramatically from day to day? ☐ YES ☐ NO

Currently, what are your child's grades in school, primarily? ☐ **A & B** ☐ **B & C** ☐ **C & D** ☐ **D & F**

Does your child receive any special education assistance? ☐ YES ☐ NO
If **yes**, what type? _____

How does your child's teacher describe your child? _____
_____

Teacher(s) Name: _____ Teacher Email: _____

BEHAVIOR & ACCOMPLISHMENTS:

Does your child play successfully with children of all ages, primarily older children, or primarily younger children?

_____

_____

Does your child experience any problems with peers? ☐ YES ☐ NO
If yes, please explain: _____
_____
_____

HOME BEHAVIOR:

All children exhibit, to some degree, the kinds of behavior listed below. Please check those you believe your child exhibits to an excessive or exaggerated degree when compared to other children his/her age:

- ☐ Hyperactivity
- ☐ Acts as though "driven by a motor"
- ☐ Doesn't learn from experience
- ☐ Plays by him/herself during free time
- ☐ Doesn't listen when spoken to
- ☐ Impulsive
- ☐ Destroys Tous
- ☐ Interrupts Frequently
- ☐ More Active than siblings
- ☐ Low frustration threshold
- ☐ Excessive number of accidents
- ☐ Sudden outbursts of aggression
- ☐ Needs to be entertained during free time
- ☐ Poor attention spans
- ☐ Heedless to danger
- ☐ Temper outbursts
- ☐ Poor memory

INTERESTS & ACCOMPLISHMENTS:

What does your child enjoy doing most? _____
_____

What does your child dislike most? _____
_____

OTHER FACTORS:

Describe any factors not covered in this form that you think are important for understanding your child:

_____

_____

_____

_____

_____