Patient Name:_____ Patient DOB:_____ Acct# _____ Date: _____

Capital Area Pediatrics
your neighborhood pediatrician

Behavioral and Developmental Pediatrics
POLLY PANITZ, M.D. FOR CHILDREN 0 - 5 YEARS OF AGE

INITIAL APPOINTMENT INFORMATION:

1. To schedule your initial appointments, please call your office select option **3**, and leave a message for the the **DB Nurse**. They will return your call within 3 business days.

2. You will schedule two initial appointments:

   - v First one hour appointment for parents only.
   - v Second 90-minute appointment for child assessment and parent discussion.
   - v Scheduled appointments will be conducted at our

     (Click here for directions)

     Falls Church Office
     407 N. Washington St.
     Falls Church, VA 22046

   Please note that there is a 48 hour (business day) cancellation policy.
   No-show appointments and appointment canceled in less than 48 hours will be charged a $100.00 no show fee.

3. A written summary will be sent to your primary clinician and to you when the visit is completed.

4. Some assessments will be enhanced by a school observation. This can be discussed at the first appointment and is **not** an insurance reimbursable service. The family will need to accept full responsibility for the $300 charge for this service. (consent is required, see page 14).

5. Please bring copies of additional documentation to the first appointment that might be helpful: IEPs, school assessment, progress reports, growth data, outside evaluations, etc.

6. Please complete this questionnaire and bring it to your first appointment.

***You will need to reschedule if your child is sick.**

****Please come without siblings for the assessment visit.***

Capital Area Pediatrics
your neighborhood pediatrician

BEHAVIORAL AND DEVELOPMENTAL: PEDIATRICS NEW PATIENT QUESTIONNAIRE

PLEASE COMPLETE AND BRING TO YOUR FIRST APPOINTMENT FOR PARENTS ONLY.
Feel free to use the reverse side for additional comments.

Date:_____ Appointment Date: _____
Child's Name: _____
Date of Birth:_____ Age of Child:_____
Address:_____
Contact Numbers:
Home: _____ Cell:_____ Work: _____

Email Address: _____
Person completing form:_____ Relationship to Child:_____

Who Recommended this Appointment?_____
Pediatrician: _____

Address (if not a CAP Clinician):_____
_____

Primary Language Spoken at Home:_____

PLEASE CHECK ALL THET ARE RELEVANT. You are concerned about your child's:

Behavior
Development
Ability to learn
Symptoms that may be Autism
Having trouble in school
Attention/Hyperactivity problems
Other, please specify: _____

Patient Name:_____ Patient DOB:_____ Acct# _____ Date: _____

1. PRIMARY CONCERNS

A. What concerns do you have today about your child?

B. What are your goals for this evaluation?

C. How long have you had these concerns?

D. Was there anything that brought these concerns on?

E. What have you tried that has worked?

F. What have you tried that has not worked?

G. In what contexts are these problems an issue?

Home

School

Other: Please describe _____

_____

_____

2. BIRTH HISTORY

Which number pregnancy was this child? _____

Prior Pregnancies? ☐ Terminations? ☐ Miscarriages? ☐ Live Births?

Was baby born early? Yes ☐ No ☐ If so, how early?_____

Birth Weight:_____ APGAR Scorces:_____

C-Section: reason for: _____

Vaginal Birth

Were there any problems with the pregnancy? Check all that are relevant:

Hospitalizations

History of Infertility

Bleeding

Medications Describe: _____

Alcohol use

Cigarette smoking

Street drug use

History of miscarriage or infant death

Was the child kept in the special care nursery? Please explain if yes.

_____

_____

Home from hospital after how many days?_____

Problems in the first month of life?_____

Describe your child as an infant including any problems:

_____

_____

- Irritability: _____
- Difficult to arouse:_____
- Poor weight gain:_____
- Feeding:

  Breastfed only: how long: _____

  Bottle fed only: how long: _____

  Both beast and bottle fed: how long: _____

3. MEDICAL HISTORY

Has your child had any of the following:

Heart disease
Irregular heart rate
Fainting
Chest pain
Frequent illnesses; describe:
Surgeries:
Hospitalizations:
Your child's development changes significantly with an illness

Past medical concerns/conditions:

Present medical concerns/conditions:

Specialists your child has seen (Include why):

1.

2.

3.

4.

4. MEDICATIONS/ALLERGIES

Medications:

Nutritional or biomedical treatments:

Confirmed Allergies:

Food intolerances/suspected allergies:

5. EARLY DEVELOPMENTAL HISTORY

Please list age at which the following milestone was first seen:

AGE	MILESTONE
	First smile
	Babbled, repeated consonant sounds like “mama” or “baba”
	Weaned off breast/bottle
	Sat alone
	Walked independently
	Spoke first meaningful words
	Put words together
	Spoke 2-3 word sentences
	Fed self with spoon/fork
	Able to dress self
	Able to separate from parent
	Potty trained
	Slept through the night

6. BEHAVIORAL CHALLENGES:

Check all that apply and describe:

Toileting: Diarrhea: Yes ☐No ☐Constipation: Yes ☐No ☐

Eating: _____

Tantrums: _____

Social skills: _____

Repetitive behaviors: (hand flapping, spinning, opening/closing doors, lining up toys, head banging, etc):_____

Aggressive behavior _____

Self injurious behavior _____

Defiance _____

7. YOUR CHILD’S STRENGTHS:

8. SLEEP HISTORY

Yes	No	
☐	☐	Wakes during night
☐	☐	Trouble getting to sleep
☐	☐	Falls asleep independently
☐	☐	Snores
☐	☐	Early riser
☐	☐	Seems sleepy, falls asleep during the day

9. DIET HISTORY

What does your child drink?

Your child drinks from:

☐ Open cup ☐ Sippy Cup ☐ Straw ☐ Bottle

Yes ☐ No ☐ Does your child feed him/herself?
Yes ☐ No ☐ Do adults feed your child?
Yes ☐ No ☐ Does your child eat a limited variety of foods?
Yes ☐ No ☐ Does he stuff food in his mouth?
Yes ☐ No ☐ Does he gag or vomit?
Yes ☐ No ☐ List your child's favorite foods:

Please describe the typical foods your child eats for each meal:

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
How many servings of dairy per day?_____

Patient Name:_____ Patient DOB:_____ Acct# _____ Date: _____

PLEASE CHECK ALL THAT APPLY				
Behavioral Traits	Rarely	Occasionally	Often	Unable to Comment
Bad temper	☐	☐	☐	☐
Whiney	☐	☐	☐	☐
Fearful	☐	☐	☐	☐
Sadness	☐	☐	☐	☐
Difficult to comfort	☐	☐	☐	☐
Difficulty with frustration	☐	☐	☐	☐
Difficulty with transitions	☐	☐	☐	☐
Difficulty with new people	☐	☐	☐	☐
Frequently ill	☐	☐	☐	☐
Frequently tired	☐	☐	☐	☐
Concerned about neatness or cleanliness	☐	☐	☐	☐
Resists cuddling	☐	☐	☐	☐
Resists getting messy, putting on clothing, or touching some textures	☐	☐	☐	☐
Startles easily with sounds	☐	☐	☐	☐
Becomes overexcited in busy settings	☐	☐	☐	☐
Puts objects in mouth	☐	☐	☐	☐
Steals	☐	☐	☐	☐
Lies	☐	☐	☐	☐
Bullies	☐	☐	☐	☐
Mean	☐	☐	☐	☐
Gets in trouble	☐	☐	☐	☐
Fearless	☐	☐	☐	☐
Has few friends	☐	☐	☐	☐
Seems sad, unhappy, has anxiety	☐	☐	☐	☐
Has difficulty with separation	☐	☐	☐	☐
Is not liked by other children	☐	☐	☐	☐
Seems unaware of other children	☐	☐	☐	☐
Does not play with other children	☐	☐	☐	☐
Has trouble with changes in routine	☐	☐	☐	☐
Asks for help too frequently	☐	☐	☐	☐
Acts as if on the go	☐	☐	☐	☐
Moods are intense	☐	☐	☐	☐
Easily distractible	☐	☐	☐	☐

***CONTINUE ON NEXT PAGE.**

Patient Name:_____ Patient DOB:_____ Acct# _____ Date: _____

PLEASE CHECK ALL THAT APPLY - Continued

Behavioral Traits	Rarely	Occasionally	Often	Unable to Comment
Loses focus easily	☐	☐	☐	☐
Unpredictable schoolwork	☐	☐	☐	☐
Daydreams	☐	☐	☐	☐
Craves excitement	☐	☐	☐	☐
Have trouble getting his attention	☐	☐	☐	☐
Asks questions	☐	☐	☐	☐
Points to things	☐	☐	☐	☐
Takes turns speaking	☐	☐	☐	☐
Expresses emotion	☐	☐	☐	☐
Uses attention getting words (“hey” or “look”)	☐	☐	☐	☐
Uses adjectives	☐	☐	☐	☐
Engages in pretend play	☐	☐	☐	☐
Makes dialogue and becomes character in play	☐	☐	☐	☐
Makes eye contact	☐	☐	☐	☐
Responds to being called	☐	☐	☐	☐
Responds when you try to get his attention: “look”	☐	☐	☐	☐
Tells a story	☐	☐	☐	☐
Can follow 1 or 2 step instructions	☐	☐	☐	☐
Uses words to ask for things	☐	☐	☐	☐
Imitates sounds	☐	☐	☐	☐
Answers questions	☐	☐	☐	☐
Asks for help	☐	☐	☐	☐

10. FAMILY HISTORY

Who lives in the child's primary home?

NAME	AGE	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		
6.		

Does the child have a secondary home? ☐ Yes ☐ No

Who lives in secondary home?

1. _____ 3. _____
2. _____ 4. _____

PARENTS

☐ Married ☐ Divorced ☐ Separated
☐ Never Married ☐ Living together ☐ Living separately
☐ Parent working away from home

Father's highest level of education: _____

Father's occupation: _____

Mother's highest level of education: _____

Mother's occupation: _____

Language(s) spoken at home: Primary: _____ Other: _____

Are you the biologic parent(s) of this child? ☐ Yes ☐ No
if not, please share history:

Other family members regularly involved with the child:

Other adults regularly involved with the child:

Does your child have a babysitter? In your home? In daycare? In-home care? What are their observations/concerns?

FAMILY HISTORY - Continued

Have any family members had the following, check all that apply and indicate whom:

CHECK IF APPLICABLE		FAMILY MEMBER
Hyperactivity	☐	
Trouble learning in school	☐	
Delayed language	☐	
Delayed/awkward social skills	☐	
Autism	☐	
Seizures	☐	
Behavior problems	☐	
Depression	☐	
Drinking or drug abuse	☐	
Other mental illness	☐	
Heart Disease/cardiac death	☐	
Irregular heart rhythm	☐	
Fainting spells	☐	
Chronic medical issues	☐	
Cancer	☐	
Parents are related	☐	
Infertility	☐	
Early menopause	☐	
Chronic neurological conditions	☐	

Has this child been exposed to any stressful experiences such as bullying, marital problems, violence, inappropriate touch or abuse, death of a loved one?
Please describe:

Additional comments you would like to share:

Patient Name:_____ Patient DOB:_____ Acct# _____ Date: _____

Capital Area Pediatrics
your neighborhood pediatrician

Authorization for Developmental Behavior Services
CONSENT FOR RELEASE OF MEDICAL INFORMATION TO SPECIALIST

I give Dr._____ permission to speak with the following professionals:

Professional:

Name: _____ Specialty: _____

Email: _____ Telephone:_____

Name: _____ Specialty: _____

Email: _____ Telephone:_____

Name: _____ Specialty: _____

Email: _____ Telephone:_____

School:

YES, please contact school (complete below)

NO, do not contact school (do not complete below)

Name of school:_____

Contact person and title:_____

Email:_____ Telephone:_____

Signature of parent:_____ Date:_____

Please bring copies of all relevant paperwork to your appointment (i.e. Medical records, laboratory results, IEP reports, assessments, etc.)

We look forward to meeting you.
Polly Panitz, M.D.

Patient Name:_____ Patient DOB:_____ Acct# _____ Date: _____

FINANCIAL RESPONSIBILITY/INSURANCE INFORMATION:

The developmental/behavioral services that are provided by Dr. Polly Panitz is highly specialized and may or may not be covered by your medical or behavior healthcare insurance policy.

Prior to your appointment, we encourage you to contact your insurance provider to familiarize yourself with and have a discussion about your benefits. Some insurance companies may state that certain codes are covered; however until the bill is processed, it is not a guarantee of payment.

Below, are some of the reasons your policy may not cover our services:

- Our providers are credentialed primary care providers and may not meet the criteria as a Behavioral Health/Mental Health Care Provider.
- Your insurance policy may not cover the diagnostic code we give to your child at the time of the visit.
- Some insurance companies may not cover specific procedure codes. (see list below)
- Some insurance companies require a pre-authorization prior to the evaluation. Please advise us if this is your policy requirement.

Initial Developmental Behavioral Visit :

CPT CODE:	SERVICE	FEE
99245	Consultation- 1 hr. w/ Parents	**$400.00**
99215	Office Visit- level 5	**$264.00**
96116	Neurobehavioral Testing (typically 2 hours)** ($168.00/hr.)	**$336.00**

*Most insurance companies will only cover this service if provided Behavioral Health/Mental Healthcare credentialed provider.

Follow up Visits:

CPT CODE:	SERVICE	FEE
99245	Consultation- 1 hr. w/ Parents	**$400.00**
99215	Office Visit- level 5	**$264.00**
99214	Follow Up- and/or MEDICATION Check (**office visit- level 4**)	**$196.00**
99354	Prolong Service (after first hour)	**$235.00**
96110	Developmental Screening with Interpretation and report (**Not to exceed 3 tests**)	**$21.00 per test**

I understand the above information and am prepared to sign a service authorization at the time of my scheduled appointment agreeing to my financially responsibility. I understand that not all services may be covered by my insurance provider and I agree to pay for any fees that may include but are not limited to co-pays, deductibles or non-covered service.

Initial HERE_____

Patient Name:_____ Patient DOB:_____ Acct# _____ Date: _____

Authorization for Developmental Behavior Services (School Observation)

Polly Panitz, M.D.

This document will serve to clarify the process for a school observation. You and your clinician will determine if an observation of your child within his/her natural environment will add to the assessment process. Please understand that this service **will not be covered by your insurance** and therefore you will be financially responsible for the flat charge of **$300.00***. By signing below, you agree to the school observation and assume the financial responsibility for the visit.

You will need to do the Following:

1. Sign and return the school observation consent to the Capital Area Pediatrics Falls Church office, if not already completed. ***Fax to 703-241-1863 - Attention: DB Nurse.***
2. Give the school contact person your permission to authorize the visit and to speak with our clinician.
3. Email the physician and your teacher to arrange for a time for the visit.
4. Once the visit has been scheduled, be certain you have a follow-up appointment with your Developmental Pediatrician to discuss the results of the school visit.
5. If your child is ill the day of the visit and the school visit needs to be cancelled, please call and email the school and the physician.

Name of School: _____

SERVICE	CPT	FEE
School Visit (this service will not be submitted to your insurance)	N/A	$300

I, _____, authorize the service to be performed within three months of signing.
(Please print name)

_____
Accompanying Adult Signature (Authorized to provide consent for patient) Date:

Your relationship to the Child: _____

Witness: _____ Date: _____