CONFIDENTIAL PERSONAL DATA

Name:_____ Date:_____

Patient:_____

Last Name First Name Middle Initial

Responsible Party (if a Minor):_____

Street Address:_____

City:_____State:_____Zip Code:_____

Phone: Home:_____ Office:_____

Mobile:_____ Other:_____

E-mail: _____

Patient Information:

Date of Birth:_____ Age:_____ Sex:____M___F

Marital Status:___Single___Married___Divorced_Separated____

Account Information:

Who is responsible for this account:_____

Relationship to Patient:_____

. . . . . .

I understand that I am responsible for any unpaid balance on my account and for charges for any missed appointments not cancelled within 24 hours.

_____ _____

Signature of Responsible Party **Date**

CHILDREN'S HISTORY FORM

Instructions to Parents: Please fill out to the best of your knowledge. Write N/A if not applicable to your child. Circle appropriate answers where indicated. Add any additional comments if you wish.

Child's Name:_____ Date of Birth:_____

Home Address_____

Home Phone_____

Pediatrician_____

Address_____

_____

Phone_____

School Currently Attending_____ Grade_____

Address_____

_____

Phone_____

Name of Person Filling Out This Form_____

Relationship to Child_____

Today's Date_____

Pregnancy with This Child- (Check Appropriate Answer)

	No	Yes	Don't Know	Comments
Anemia	____	____	_____	_____
High Blood Pressure	____	____	_____	_____
Toxemia	____	____	_____	_____
Swollen Ankles	____	____	_____	_____
Kidney Disease	____	____	_____	_____
Bleeding	____	____	_____	_____
Virus	____	____	_____	_____

	No	Yes	Comments
Rh Incompatibility	____	____	_____
Hospitalization	____	____	WHEN?_____
			WHY?_____

Birth History

Name of Hospital _____

	No	Yes	
Were You Given Medication?	____	____	
Did You Have Natural Childbirth?	____	____	
Were You Under Anesthesia?	____	____	
Was Labor Induced?	____	____	Why?_____

	No	Yes
Was This A Breech Delivery?	____	____
Did You Have a Caesarian?	____	____

Why?_____

Any Complications?_____

Infancy

	No	Yes
Did You Have Problems With Feeding?	____	____
Describe_____		
Was The Baby Colicky?	____	____
How Many Months? _____		
Did The Baby Require Formula Change?	____	____
Describe_____		
Difficulty Sucking?	____	____
Difficulty Chewing?	____	____
Fail To Gain Weight?	____	____

	NO	YES
Fail To Grow Normally?	____	____
Describe_____		
Was the Baby Normally Active?	____	____
Describe_____		
Did The Baby Have Tremors?	____	____
	NO	YES
Did The Baby Have Convulsions?	____	____
Describe_____		

Development

Motor

	Age in Months	Years
Sat Alone	_____	_____
Walked Without Holding On	_____	_____
Fed Self	_____	_____
Dressed Self	_____	_____
Tied Shoes	_____	_____
Pedaled Tricycle	_____	_____
Rode Bicycle	_____	_____
Swam	_____	_____

Language

	Age in Months	Years
Spoke First Words	_____	_____
Put 2 to 3 Words Together	_____	_____
Good Sentence Structure	_____	_____

Toileting

	Age in Months	Years
Trained for Urine	_____	_____
Trained for Bowels	_____	_____

Bed Wetting NO_____YES_____

Age Started _____

How Many Times A Month? _____

Age Controlled _____

Behavior

	No	Yes
Shy		
Immature		
Well Behaved		
Stubborn		
Impulsive		
Temper Tantrum		
Thumb Sucking		
Head Banging		
Nail Biting		
Average Intelligence		
More Active Than Other Children		
Clumsy In Using Hands		
Poor Handwriting		
Clumsy In Walking		
Tics and Twitching		
Excessively Fidgety Or Have Trouble Staying In Seat		
Difficulty Paying Attention		
Has Difficulty Staying At One Activity For Reasonable Length Of Time		

Sleep Problems

	No	Yes
Difficulty Staying Asleep	____	____
Frequent Wakening	____	____
Early A.M. Wakening	____	____

	No	Yes
Sleep Walking	____	____
Nightmares	____	____

Past Medical History

	No	Yes
Has Child Had Meningitis Or Encephalitis?	____	____

At What Age in MONTHS_____ YEARS_____

Head Injury?	____	____

At What Age in MONTHS_____ YEARS_____

Loss of Consciousness?	____	____

Present Medications:

NAME	DOSE	TIME GIVEN	REASON GIVEN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

	No	Yes	Results
Have Any Special Tests Done?	____	____	_____
Eye Exam?	____	____	_____

Age in MONTHS_____YEARS_____

Hearing Exam?	____	____	_____

Age in MONTHS_____YEARS_____

Other?	____	____	_____

Name of Test_____

Have You Consulted Any Other Medical Specialists For The Child? NO____YES_____

If So, Whom?_____At What Age?_____

Reason_____Results_____

Has The Child Had Any Emotional Adjustment or Behavioral Problems? NO___YES___

Describe At What Age And What Type_____

_____

Has the Child Received Any Psychological or Psychiatric Treatment? NO_____YES____

By Whom?_____When?_____

Place_____

School History (if applicable)

			AGE STARTED	
	No	Yes	Months	Years
Did Child Attend Nursery School?	____	____	_____	_____
Any Problems?	____	____	Describe:_____	
			_____	
Did Child Attend Kindergarten?	____	____	_____	_____
Any Problems?	____	____	Describe:_____	
			_____	
First Grade – Age Started _____				
Any Problems?	____	____	Describe:_____	
			_____	

Present School Attending:_____Grade_____

Has The School Reported Problems With:

	No	Yes
Reading		
Spelling		
Arithmetic		
Writing		
Behavior		
Social Adjustment		
Attention Span		
Distractibility		
Hyperactivity		
Following Directions		
Getting Along With Children		

Describe Any Problems Noted Above In the Space Below:

_____

_____

_____

	NO	YES
Does Your Child Like School?		
Has Any Psychological Testing Been Done?		

If So, Where?_____By Whom?_____

What Recommendations Were Made?_____

Is This Child In Special Education Classes?		

What Kind?_____

At What Age Was (S)he Placed There?_____

	No	Yes
Does Your Child Receive Any Special Services In School?	____	____
(Resource Room, Tutoring, Remedial Reading, Speech, etc.)	____	____
Has The Child Received Special Help Privately?	____	____

What Type?_____

By Whom?_____AGE:_____

How Often?_____

Family History (Under Parents List Names Of Children In Order Of Birth)

	AGE	Grade EDUCATION	OCCUPATION	HEALTH	SCHOOL OR BEHAVIORAL PROBLEMS
Father					
Mother					
_____					
_____					
_____					
_____					

Social History

Who Lives At Home?_____

What Language Is Spoken At Home?_____

	NO	YES
Are There Significant Marital Conflicts?	____	____
Are There Significant Conflicts Between Child and Parents?	____	____
Are There Significant Conflicts Between The Children?	____	____
Do Parents Agree On How To Discipline The Child?	____	____

Who Disciplines and How?_____

_____

How Does Child Respond To Discipline?_____

Does Child Have Difficulty Getting Along with Children His Own Age? NO____YES____

Does Child Have Difficulty Getting Along with Adults? NO____YES____

Does Child Have Difficulty Getting Along with Brothers/Sisters? NO____YES____

Does Child Have A Best Friend? NO____YES____ Same Sex? NO____YES____

What Special Interest Does The Child Have?_____

Financial Policy

Thank you for choosing me as your mental health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of the Financial Policy, which you are *required to read and sign prior to any treatment*.

All patients must complete our Information and Insurance form before seeing the doctor.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE -
- WE ACCEPT CASH, CHECKS, VENMO, OR ZELLE –
There is a convenience fee of 3% when using a Credit Card

Appointments are scheduled for the same day and time each week unless altered by the doctor or yourself in advance.

Timely Payment
I understand that *payment is expected upon receipt of service.* I agree to pay 1.5% per month if I am delinquent in my account and have to be re-billed. I also understand that should any action need to be taken to collect for professional services rendered, the professional provider shall be entitled to recover any attorney fees.

Regarding Insurance
We do not accept insurance.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Any payment by received by credit card will have a convenience fee of 4%.

Adult Patients
Adult patients are responsible for full payment at time of service.

Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid by credit card or cash.

Missed Appointments
We require, *at least 24 hours in advance*, to cancel an appointment. Any calls made after 5:00pm or on Saturdays and Sundays to cancel appointments will **not** be accepted. Thus, if your appointed is after five o'clock, *you must call before five o'clock on the previous day*. If your appointment is on a Monday, *you must call before 5:00pm on the previous Friday*. Otherwise, you will be charged for the appointment. **Please help us serve you better by keeping scheduled appointments**.

Telephone Time
Unless it is an emergency, all therapeutic contacts take place in the office. Should you request therapeutic interventions on the telephone you will be charged $275 per hour prorated in .10 hours. Most insurance companies will not reimburse telephone time.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

X_____ Date _____
Signature of Patient or Responsible Party

Wade H. Silverman, Ph.D.
American Board of Professional Psychology Diplomate

Notice of Privacy Practices – Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP and you may have a copy of this to read and refer to it for more information. However, we can't cover all possible situations so please talk to our Office Manager (see the end of this pamphlet) about any questions or problems.

We will use the information about your health, which we get from you or others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities, which are called, in the law, health care operations. After you have read this NNP, we will ask you to sign a consent form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If you or we want to use or disclose (send, share release) your information for any other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Of course we will keep your health information private, but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place, which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information we have about you such as your medical billing records. You can even get a copy of these records, but we may charge you. Contact our Office Manager to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kind of changes (called amending) to your health information. You have to make this request in writing and send it to our Office Manager. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NNP, we will post the new version in our waiting area and you can always get a copy of the NPP from our Office Manager.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Office Manager and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact the Psychologist who is **Dr. Wade H. Silverman** and can be reached by phone at 786-536-7033.

The effective date of this notice is April 30, 2023.

Also, you may have other rights, which are granted to you by the laws of our state and these may be the same or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

Signature:_____ Date:_____

Wade H. Silverman, Ph.D.
Diplomate American Board of Professional Psychology
(786)-536-7033 ; (561)-999-9890

Aventura
1031 Ives Dairy Road
Suite 228
Aventura, FL 33179

Boca Raton
4710 NW 2nd Avenue
Suite 104
Boca Raton, FL 33431

Patient Rights

- The right to refuse and/or terminate treatment at any time;
- The right to a complete description and explanation of any treatment;
- The right to refuse any electronic and/or visual recording of my treatment;
- The right to confidentiality whereby information revealed to me during treatment will be kept strictly confidential and will not be revealed to anyone without authorization. However, **knowledge of child abuse, intent to harm others or myself will be reported.**

I hereby certify and I understand the above and have been informed of policies and procedures regarding appointments and fees. Furthermore, I authorize treatment by Wade H. Silverman.

_____

Signature of Patient ***Date***

_____

Signature of Guardian (if applicable) ***Date***

Wade H. Silverman, Ph.D.

Child Clinical Fees

OUTPATIENT PSYCHOTHERAPY

SERVICE:	**FEE:**
Diagnostic Interview	$275.00/hr.
Individual Psychotherapy	$225.00/45 min. $275.00/1 hr
Psychological Testing	$275.00/hr.

Assessment

SERVICE:

Behavioral Assessment System for Children (BASC-3)

Millon Adolescent Clinical Inventory (MACI)

Minnesota Multiphasic Personality Inventory (MMPI-A)

Millon Pre-Adolescent Clinical Inventory (MPACI)

Reynolds Adolescent Depression Scale-2 (RADS-2)

Piers-Harris 3

Reynolds Child Depression Scale-2 (RCDS-2)

Reynolds Child Manifest Anxiety (RMAS-2)

Wechsler Intelligence Scale for Children (WISC-V)