

DEVELOPMENTAL-BEHAVIORAL PEDIATRICS



About Developmental-Behavioral Pediatrics

Thank you for your interest in Developmental-Behavioral Pediatric Services at East Milton Pediatrics. We currently have one Developmental-Behavioral Pediatrician, Dr. Katherine Trier, who is accepting new patients for developmental-behavioral care. Dr. Trier sees children for developmental pediatrics from birth through age 22 years.

What is a Developmental-Behavioral Pediatrician?

Developmental Pediatrics is a subspecialty of pediatrics that focuses on the assessment, diagnosis and management of children and adolescents with developmental and behavioral concerns. Developmental Pediatrics can be thought of as a cross between General Pediatrics, Psychiatry and Neurology. Developmental Pediatricians do NOT conduct neuropsychological testing, but do complete diagnostic testing for many developmental conditions.

What conditions do a Developmental-Behavioral Pediatrician address?

Developmental Pediatricians are trained to evaluate and manage typical and atypical developmental concerns. Common diagnoses addressed include: autism spectrum disorders, cognitive impairments, attention deficit hyperactivity disorder (ADHD), learning disorders, anxiety/OCD, depression, impulse control disorders (e.g., *Intermittent Explosive Disorder (IED)* or *Disruptive Mood Dysregulation Disorder (DMDD)*), substance use disorders, tics/Tourette's, genetic/chromosomal conditions (e.g., Down syndrome, Prader-Willi Syndrome) and communication/motor skills impairments. Developmental Pediatricians also help families to address behavioral challenges that can be part of typical development including sleep disruption, problematic screen time usage, picky eating, toileting, tantrums, etc. Developmental Pediatricians work with families to understand a child's individual needs and to develop an individualized treatment plan to support the child's optimal development.

Do Developmental-Behavioral Pediatricians prescribe medications?

As a trained child behaviorist, Dr. Trier first likes to work with parents to implement behavioral strategies to address behavior, particularly in typically-developing children (e.g., sleep difficulties, tantrums, etc.). However, many children do require medication to treat behavioral or mental health conditions. Dr. Trier is also trained in psychopharmacology management and can discuss during appointments whether medications are indicated for your child.

What is the Process for being evaluated by a Developmental Behavioral Pediatrician?

The first step is to complete the intake paperwork which will be reviewed by Dr. Trier to ensure that a Developmental appointment is appropriate. If appropriate, Dr. Trier will determine whether your child will need an initial consultation or an initial consultation and developmental testing. Both the initial consultation and developmental testing take about 1 to 1.5 hours for each session. If your child will require developmental testing, a parent conference (just

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parents/guardians, usually no child present) will be scheduled the following week to review the results of testing.

Are appointments in-person or virtual?

Initial consultations and developmental testing are always in-person so Dr. Trier can meet you and your child. Parent conferences and follow-up appointments can either be in-person or virtual depending on the needs of your child.

How often will my child be seen by Dr. Trier?

Children who are on medications with Dr. Trier are usually seen more frequently than children who are not on medications. The frequency of developmental appointments will be determined after your child's initial consultation. In order for Dr. Trier to continue prescribing medications for your child, your child **MUST** be seen at least every 6 months.

Does Dr. Trier work with the schools?

Part of the job of a Developmental Pediatrician is to help advocate for the needs of children in the community and in the school setting. Dr. Trier can review school-based testing, make diagnoses and school-based recommendations, as well as review proposed Section 504 Plans and Individualized Education Programs (IEPs). Due to her schedule, Dr. Trier usually cannot attend school meetings in-person, but can communicate directly with schools and therapists to advocate for the needs of your child.

For additional information see our website: <https://www.eastmiltonpediatrics.com/>

Insurance/Billing/Referrals

Our office will submit claims for Developmental-Behavioral appointments to the insurances with which we are contracted. We are In Network for developmental appointments with Aetna, Blue Cross, Cigna, Fallon, Coventry (HCVM), Harvard Pilgrim (includes Passport plans), Health New England (*Western Mass Only*), Humana, Multiplan (PHCS), Tufts, Three Rivers, United Health Plan, Unicare, WellSense BCH ACO, and MassGeneral Brigham Commercial Plans (formally known as Allways). We are not in network with any Limited Network plans or alternate/complementary network plans. All other plans not listed here would be considered out of network. You can verify we are in your specific plan network on your insurance website ("Find a Doctor") or by calling your member services number on your insurance card. *Please note we are contracted **medical** providers, not mental health providers.*

If your child is covered by any insurance that is out of network, we recommend that you call the insurance company to verify whether they will reimburse you for these services as "out of

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network.” You would be required to pay our charges at the time of your appointments. We will provide you with an estimate prior to your appointment at your request. We will give you a receipt with the appropriate codes to submit to your insurance company for reimbursement. You may be able to receive lower cost services from in network providers.

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 for a sooner appointment, you may request that your doctor date the referral effective the day you call for it rather than the date of the appointment you were originally given. Otherwise, in the event that your appointment is moved to an earlier time, your primary care doctor would need to provide a new referral reflecting the new date. **If you do not have a referral on the date of your appointment, you will be required to pay for the visit in full, in advance.** You may then submit our statement to your insurance company for reimbursement.

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).

This packet can be mailed or emailed to our receptionists at DBP@EastMiltonPediatrics.com

Outside Testing/Reports

Please bring copies of any relevant information to our office on the day of your appointment (e.g., IEP, most recent school testing or reports, other evaluations). 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 our doctors send home for completion (e.g., developmental 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 for 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 1 ½ hours for your initial consultation appointment.

All efforts are made to make your child's experience comfortable. During the first appointment, we will often check your child's hearing, vision and vital signs.

Following your consultation appointment, a summary letter will be sent to your pediatrician. We cannot send consultation letters directly to your child's school.

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Neurodevelopmental Testing Appointments

Dr. Trier may schedule your child for neurodevelopmental testing following your consultation. Please set aside approximately 1½ hours for this appointment. Note that this is not the same testing provided by schools for a school-based evaluation and it is **not a Neuropsychological Evaluation**. Either of these may also be recommended depending on the doctor's findings.

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

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

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PATIENT REGISTRATION FORM

Child's First	Middle	Last Name	Date of Birth	Sex
Street Address		City	State	Zip
Preferred Phone # (for office to contact you)		How did you hear about us? <input type="checkbox"/> Physician <input type="checkbox"/> Family/Friend <input type="checkbox"/> Mailing <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> Other _____		
Ok to leave messages Voice <input type="checkbox"/> or Text <input type="checkbox"/>		Email address for Office News and Updates and other correspondence		
Parent A. Mother's Name (Father if 2 dad family)		Parent B. Father's Name (Mother if 2 mom family)		Parent's Marital Status S M D W
Legal Guardian (if different from above) or if divorced, the person who has legal and physical custody (Legal documentation required if not joint custody)				
Parent/Guardian Street Address (if different from above)		City	State	Zip
Parent/Guardian Home Phone #	Parent A Cell Phone #	Parent B Cell Phone #	Work # if ok to call	
Next of Kin/Emergency Contact Name		Relationship	Telephone #	

PRIMARY INSURANCE COMPANY – EFFECTIVE DATE

Name of Insurance Company	Policy ID #	Group #	
Claims Address	City	State	Zip Telephone #
Name of Policy Holder	Date of Birth	Relationship to Insured	Type of Plan: HMO/PPO Deductible? Referrals Needed?
Employer Name and Address			

SECONDARY INSURANCE COMPANY – EFFECTIVE DATE

Name of Insurance Company	Policy ID #	Group #	
Claims Address	City	State	Zip Telephone #
Name of Policy Holder	Date of Birth	Relationship to Insured	Type of Plan: HMO, PPO Deductible? Referrals?
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 insurance benefits be paid directly to East Milton Pediatrics. I also authorize East Milton Pediatrics 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.

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Signature _____ Date _____

PATIENT HISTORY FORM

Child's Name: _____ Preferred/nickname: _____ DOB: _____

Your Name: _____ Relation to child: _____

Referred by: _____

Date of completion of this form: _____

Child's Primary Care Physician: _____

Address: _____

Telephone: _____

Urgent Concerns:

Please **CHECK** any applicable boxes if you have urgent medical concerns.

MEDICAL: BEHAVIORAL / PSYCHIATRIC

- | | |
|----------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of skills/developmental regression |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Difficulty swallowing or choking | <input type="checkbox"/> Severe weakness or lack of coordination |
| <input type="checkbox"/> Inability to tolerate exercise | <input type="checkbox"/> Severe headache |
| <input type="checkbox"/> Suicidal thinking or attempt of child | <input type="checkbox"/> Safety of any family members (including this child) |

Please explain: _____

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

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HOME SETTING:

Child lives with:

- | | | |
|----------|--------------------------|------------|
| 1) _____ | Relation to Child: _____ | DOB: _____ |
| 2) _____ | Relation to Child: _____ | DOB: _____ |
| 3) _____ | Relation to Child: _____ | DOB: _____ |
| 4) _____ | Relation to Child: _____ | DOB: _____ |
| 5) _____ | Relation to Child: _____ | DOB: _____ |

Does your child spend time at another home? Yes No If Yes who resides there? _____

Parent A (name): _____

Age: _____

Highest education attained (e.g., high school, college, graduate degree): _____

Occupation: _____

Parent B (name): _____

Age: _____

Highest education attained (e.g., high school, college, graduate degree): _____

Occupation: _____

Are there any particular stresses at home? _____

How long have you lived in your present home and community (e.g., any recent moves or changes in living environment)? _____

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Language (s) Spoken at Home: _____

Ethnicity: _____ Race: _____

DAYCARE/SCHOOL:

Did/Does your child receive Early Intervention services (below 3 years) Yes No If so, what type of service and for how long?

Did/does your child go to preschool or daycare? Yes No

Were/are there any problems there? Yes No

Was/is your child able to follow a routine in the early childhood setting? Yes No

What grade is your child in: _____

What daycare/school does your child attend (please note the town): _____

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

___ Good ___ Fair ___ Poor

Has your child had any problems learning sounds associated with symbols such as letters and numbers?

Yes No

PAST EVALUATIONS:

Has your child ever completed developmental/psychological testing? Yes No

If yes,

Where: _____ Performed by: _____

When: _____

What did you learn from this (e.g., any diagnosis such as ADHD, autism, learning disability)?

What other developmental diagnoses has your child received:

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Has your child been seen or currently being followed by any other Specialists (e.g., Developmental-Behavioral Pediatrician, Neurologist, Psychiatrist)?

Yes No If so when, by whom: _____

Is your child currently on the waitlist for evaluation by another specialist (e.g., Developmental-Behavioral Pediatrician, Neurologist, Psychiatrist, Psychologist)? If yes, what specialty?

Is your child currently on a Section 504 plan? Yes No

Is your child currently on an Individualized Education Program (IEP)? Yes No

Date of last school-based evaluation: _____

Services your child is receiving **IN SCHOOL**:

- Speech Therapy Occupational Therapy Physical Therapy ABA/Behavioral Therapy
 Special Education (reading, writing, math, executive functioning) Extended School Year
 Other _____

THERAPIES

Is your child currently receiving or has your child in the past received any services or therapies **privately**? (e.g., Speech, Occupational, Physical Therapies, ABA, other)

Please include dates, where performed, and frequency.

*** Please bring copies of most recent IFSP, Section 504 Plan or IEP to the consultation ***

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Has your Child ever had any of the following tests/procedures:	If yes, when, where and what were the results?
Genetic testing Yes No	
EEG Yes No	
CT scan or brain MRI Yes No	
Sleep Study Yes No	
Hearing Test Yes No	
Vision Test Yes No	

PRENATAL HISTORY:

Please check if prenatal/birth history is **unknown**

Age of Mother at birth: _____
 Age of Father at birth: _____

Was your child born in a hospital? Yes No

Were there any concerns during the pregnancy? _____

Did the child's biological mother take any medications besides iron and vitamins during the pregnancy?

Yes, please list No

Any alcohol Yes, Please list amount/frequency _____ No

Drugs Yes, Please list amount/frequency _____ No

Cigarettes Yes, Please list amount/frequency _____ No

Any particular stressors Yes No Please describe if yes _____

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Was this pregnancy Full-term? Yes No _____

Type of delivery? Vaginal C-Section

If C-section reason _____

What was the child's birth weight? _____

Any troubles at the time of birth or while in the hospital? _____

After coming home, what was your child like as a baby? _____

Any feeding issues or colic? _____

Any trouble establishing rhythms of eating and sleeping? _____

FAMILY HISTORY: Please indicate conditions that run in the family by writing the relation of the person to your child (e.g., Maternal grandmother or "mother's mom")

School Problems
No Yes _____
Attention Disorders
No Yes _____
Learning Disability
No Yes _____
Anxiety Disorders
No Yes _____
Tics/Tourette Syndrome
No Yes _____
Panic Attacks
No Yes _____
Depression
No Yes _____
Suicide Attempts
No Yes _____
Alcoholism
No Yes _____
Other Mental Health issues
No Yes _____

Autism/PDD/Asperger Syndrome
No Yes _____
Genetic Disorders
No Yes _____
Intellectual Disability
No Yes _____
Seizures/Epilepsy
No Yes _____
Hereditary deafness or blindness
No Yes _____
Allergy/Asthma
No Yes _____
Heart disease before 50 years of age
No Yes _____
Unexpected/unexplained death
No Yes _____
Substance Abuse
No Yes _____
Any other problems of development
No Yes _____

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Please indicate if your child has experienced any of the following:

Seizures	No	Yes	Weight loss or gain	No	Yes
Tics (repetitive movements or sounds)	No	Yes	Problems with urinating or with kidneys	No	Yes
Easy bleeding/bruising	No	Yes	Constipation or diarrhea	No	Yes
Heart beating "funny" or fast	No	Yes	Abdominal pain	No	Yes
Chest Pain	No	Yes	Rash or other skin problem	No	Yes
Difficulty breathing	No	Yes	Broken bone	No	Yes
Problems with hearing	No	Yes	Problems with vision	No	Yes
Problems with immune system	No	Yes	Recent febrile illness	No	Yes

Has your child received all recommended childhood vaccines? No Yes

If no please explain _____

To assist us in making an accurate assessment of your child's issues, we need a detailed picture of your child's development and behaviors. Please answer the following questions to the best of your ability. Completion of this detailed history will allow more time for discussion and observation during your appointment.

Developmental History:

Any problems with typical milestones such as sitting, standing, or walking? _____

Did your child babble (e.g., *dada*, *baba*) before 12 months? Yes No

How old when your child said first word? _____ Put 2 words together? _____

When you called your child's name at 10 months of age, did your child look at you? Yes No

Did your child follow where you were pointing to an object of interest? Yes No

Did your child point to objects of interest to your child as they got a little older? Yes No Sometimes

Did your child bring books or games to you to play with them after they learned to walk? Yes No

What was your child's play like when they were 18 months of age? _____

Did your child like miniatures such as toy kitchen sets, tool sets, farm animals, etc.? Yes No

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Between 2 and 3 years of age did you see make-believe play begin? Yes No

Did you ever see your child focus in an unusual way at a part of a toy such as a wheel or a reflection of light on a toy? Yes No

Did your child ever pass objects slowly in front of their eyes or look at the toys only from the side?
 Yes No

Has your child ever displayed rituals or obsessions or other repetitive behaviors? Yes No

If yes, please describe and indicate age when first appeared: _____

Any difficulties with learning how to use buttons, snaps and zippers? Yes No

When did your child eat independently with fork, cup and spoon? _____

When did your child first learn to walk independently: _____

Is your child interested in sports? Yes No

Are you concerned about your child's motor coordination? Yes No

When did your child assist with dressing and undressing? _____

When was your child toilet trained? _____

Does your child have any urine/stool accidents now? Yes No

Do you have any concerns about your child's diet? Yes _____ No

In preschool/daycare did/does your child show interest in what other children were/are playing?

Yes No

Did your child want to join in with the play of other children after age 4? Yes No

Were there difficulties with the transition to kindergarten Yes No

Is your child hypersensitive to touch (e.g., tags bother, sock line has to be "just right") Yes No

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Is your child either attracted to or repelled by any types of food including issues of texture, taste or smell?

Yes No

Is your child hypersensitive to sounds? Yes No

Does your child seek out physical play or pressure? Yes No

Does your child strongly react to change, such as stopping a favorite activity to go in the car? Yes No

Does your child notice familiar routes in the car and comment on them? Yes No

Does your child get upset if there is a deviation from the expected route/routine? Yes No

Does your child struggle with transitions away from preferred activities or objects? Yes No

Does your child have any intense interests (e.g., a subject that s/he knows everything about, or a topic that s/he persistently returns to in conversation or play)? Yes _____ No

Does your child have any difficulty socializing or making friends? Yes No

Are you concerned about your child's ability to play (e.g., parties and playdates)? Yes No

Does your child understand facial expressions? Yes No

Can your child carry on a typical back and forth conversation? Yes No

Sleep:

What time does your child get into bed at night? _____

How long does it take your child to fall asleep? _____

Does your child routinely wake up during the night? Yes _____ No

Is your child a restless sleeper? Yes No Does your child snore? Yes No

Have you ever thought that your child might have stopped breathing during sleep? Yes No

At what time does your child usually wake up in the morning? _____

Does your child seem rested in the morning? Yes No

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Safety:

Has the Department of Children and Family Services ever been involved with your family?

Yes No. If Yes please give dates and details _____

Have the police ever been called to your home? Yes No. If Yes please give dates and details.

Do you ever feel unsafe when taking care of your child? Yes No. If Yes please give details.

Do you ever feel that your child is or could be a danger to those around them? Yes No

If Yes please explain: _____

Are there any concerns for your child's or other family members safety at home, school or elsewhere ?

Yes No If Yes please give details: _____

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NOTICE OF HIPAA PRIVACY PRACTICES

This is a summary of how we use and disclose your Protected Health Information. Please read the full Notice of Privacy Practices available on our web site or at our front desk or request a copy to be mailed to you, prior to signing this form.

- 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: ***see full Notice of Privacy Practices for examples***
 - 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 by voice message, text or email.
 - 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. ***See full Notice of Privacy Practices for instructions.*** Contact the Office Manager with questions or concerns.
- E. A copy of the full description of East Milton Pediatrics privacy practices has been made available to me. I understand my rights and how my protected health information can be used by East Milton Pediatrics.

This Notice of Privacy Practices is effective as of today's date: _____

Patient's Name: _____

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Parent/Guardian Signature: _____

PAYMENT and CANCELLATION POLICY

Child's Name: _____ Date of Birth: _____

Due to the considerable time involved with Developmental and Behavioral Appointments, our office has developed the following Cancellation and Payment Policy:

Consultation and Testing appointments require 5 days' notice of cancellation during regular business hours only, or a charge of \$300.00 will be applied.

Follow Up appointments canceled with less than 48 hours' notice, made during regular business hours only, will incur a \$150 charge.

Calls for cancellations must be received during regular business hours Monday-Friday.

Calls will not be accepted by the afterhours emergency answering service for cancellations.

Monday appointments must be canceled by 5pm the preceding Friday.

An active credit card number is required to be kept on file with our PCI compliant secure gateway, to which we will bill **all outstanding balances** which may include deductible, copayment/coinsurance, appointments missed or canceled without required notice, insurance denials for non-covered services, partial payment, no referral or inactive insurance. A fee of \$25 will be applied to declined cards.

Your signature below indicates that you authorize East Milton Pediatrics to charge your credit card for patient balances as listed above. A receipt will be sent upon request once your payment has been processed.

A credit card will need to be provided at the time your appointments are scheduled.

Cardholder's SIGNATURE: _____ Date: _____

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

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Insurance and Billing Information:

Our office will submit claims for Developmental-Behavioral appointments to all insurances we are contracted with if you have a verifiable active policy.

The following is a list of our most commonly applied insurance codes for Developmental-Behavioral Appointments. *Please note this is not an inclusive list and may change without notice.* If you have any questions or concerns about what your insurance will pay, or **if you have a deductible plan**, please contact your insurance provider's member services department for **medical services** prior to scheduling your appointment (s). Please call our office if your insurance denies any of the codes listed below. By signing this waiver, you understand that you are responsible for payment of non-covered procedures and insurance determined balances and agree to payment via your credit card on file.

Developmental Behavioral Pediatrics Codes: *Some appointments may be via telehealth.*

Consultation visit:

Developmental-Behavioral Consultation, new patient (99245,99244, 99205) Established patient 99215+99147x units if greater than 55 mins. **Prolonged time 99147 not covered by insurance**, parent responsibility.

Otoacoustics Emissions hearing screening (92587) Vision screening (99177, 99173)

Assessment and screening questionnaires (96127,96110, 96160, 96161) **more than one screening may be administered, insurance may only pay for 1**, or charge to deductible, any not covered are patient/parent responsibility) 96127 not covered by Allways or MassHealth.

Neurobehavioral Testing Appointment Developmental Testing (96112/96113x 4 units). **Not covered by MassHealth. May apply to deductible or units may exceed your insurance limit.**

Parent Conference Office visit codes - 99214 or 99215

Follow up appointments Office visit codes- 99214, 99215.

Prolonged visit code - if your parent conference or follow up appointment runs longer than 40 minutes (99147) **Not covered by insurances** therefore parent responsibility.

Review of records outside of your appointment time (99358) **Telephone calls not medication related** (99442,99443,99444) **Not covered by some insurances.**

Telehealth calls (99441,99442,99443) Includes communication to manage an issue directly with provider, or from provider via nurse or portal.

Please be aware that review of records outside of your appointment time, requests for telephone consultations with parents, therapists, or school personnel and **additional** reports (e.g., letters to schools) will not be covered by your insurance and will require payment in advance.

This list is representative but not inclusive. I understand that these or other applicable codes may not be covered by my insurance or may be applied to my deductible and if not paid by my insurance, I am responsible for payment in full. A copy of the *Office Financial Policies and Patient's First Law* has been made available to me via the website. I understand that balances are due upon receipt and are subject to a \$10 billing fee if payment or a payment plan is not addressed within 30 days. Returned checks or declined charges will incur a \$25 fee.

Child's Name: _____ Date: _____

Parent/Guardian Signature: _____