Danielle Farese Milburn, Ph.D.

Lake Norman Location:
19453 W. Catawba Avenue, Ste. B
Cornelius, NC 28031

Charlotte Location:
2014 Park Dr.
Charlotte, NC 28204

Phone: (704)895-6379
Fax: (704)895-6380
danielle_milburn@bellsouth.net

Cover Letter

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

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

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

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 are: Monday - Friday: 9:00 A.M. to 5:00 P.M.
You are requested to give this office adequate notice of cancellation. No less than 24 hours is expected. When this is not the case, you will be held responsible for a "no show" fee of $85.00. Consideration will, of course, be given if an emergency arises.

Testing for area schools:
Psychological testing is at $175.00 per hour with a $25.00 Report Writing/Administrative Fee

Please try to arrive on time for your appointment. While we currently make efforts' to allocate additional time in our schedule in anticipation of delays, due to the heavy volume of testing from December thru January, we will have to implement a late arrival policy. Persons arriving 10+ minutes late to their appointment may need to be rescheduled. Dr. Milburn will have to see (based on the schedule of the day) if you can still be seen with the remaining time. Otherwise, it would be unfair to other clients who arrived on time. We are sorry for any inconvenience this may cause, should you need to be rescheduled.

If you are unfamiliar with the location of our office(s), 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. Note that our office in the Charlotte area is located on **PARK DRIVE** and not on Park Road.

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 a.s.a.p. We will do everything possible to keep your appointment on a timely schedule.

Danielle Farese Milburn, Ph.D.
Lake Norman Location:
19453 W. Catawba Ave. Ste B
Cornelius, NC 28031

Charlotte Location: Phone: (704)895-6379
2014 Park Dr Fax: (704)895-6380
Charlotte, NC 28204 danielle_milburn@bellsouth.net

DEVELOPMENTAL QUESTIONNAIRE

Your kindness in furnishing the following information will be appreciated. This information will be used in strict confidence to assist in evaluating and/or treating your child.

GENERAL INFORMATION

Child's Name: _____Birth Date: _____ Age: _____ YR._____MTH.

Sex: _____ Living With: _____ Phone: (_____)_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Pediatrician/Family Physician: _____

FAMILY HISTORY

	Father's 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:

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?

Learning Difficulties (Reading, Writing, Math)	YES_____	NO_____
Attention Deficit Disorder (ADD-with or without hyperactivity)	YES_____	NO_____
Emotional Problems	YES_____	NO_____
Seizures	YES_____	NO_____
Other psychiatric illnesses such as Depression, Manic Depression	YES_____	NO_____
Schizophrenic, Autism, Mental Retardation, Alcoholism/Drug Addiction	Yes_____	NO_____

List brothers and sisters of the child:

Name	Age	Sex	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____ _____ _____
_____ _____ _____ _____

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

MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age, the incident or illness 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 test 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 him/her? _____
_____

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 toys
☐ 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 span
☐ 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:_____
_____
_____

Danielle Farese Milburn, Ph.D.

Lake Norman Location:
19453 w. Catawba Ave. Ste B
Cornelius, NC 28031

Charlotte Location: Phone: (704)895-6379
2014 Park Dr. Fax: (704)895-6380
Charlotte, NC 28204 danielle_milburn@bellsouth.net

AUTHORIZATION TO DISCLOSE INFORMATION

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

Information Disclosed FROM: **Information Disclosed TO:** (Attach list if needed)

Danielle Farese Milburn, Ph.D. Name: _____

2014 Park Dr. Address: _____

Charlotte, NC 28204 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: _____