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

Please review our *Welcome Letter* and sign the last page. Please detach 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 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.

Thank you for the opportunity to work with you and your family. For any questions or concerns please call my assistant at 704-895-6379. If at any time you need to speak with me directly, you may call 704-728-9672.

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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:

- What the goals of treatment are
- How long patient care might take
- How much my services cost, and how I handle money matters

After you read this brochure we can discuss, in person, 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 next meeting. When you have read and fully understood this brochure, I will ask you to sign it at the end.

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. Let me describe how I see my services.

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.

Relative to my approach to conducting assessments, I strive to provide comprehensive neuropsychological, psychological, and/or psychoeducational evaluations that are tailored to meet the needs of the respective client. I am able to 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 rooted in, and 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 with great care all the information you share with me. 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 will tell no one what you tell me. I will not even reveal that you are receiving treatment from me.

In all but a few rare situations, your confidentiality (that is, 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 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.

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.

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. We are sorry for any inconvenience this may cause, should you need to be rescheduled

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.

Psychological testing:
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 my services are paid for. Meeting this responsibility shows your commitment.

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

***Regular therapy services**:* Initial Consultation- Session of 60 minutes, the fee is $ 175.00. Therapy session of 60 minutes, the fee is $ 150.00.
(Consultation Insurance Code 90791; Counseling Insurance Code 90837)

***Psychological testing services**:* $ 175.00 per hour. Psychological testing fees include the time spent with you, the time needed for scoring and studying the test results, and the time needed to write a report on the findings. The amount of time involved depends on the tests used and the questions the testing is intended to answer. The final appointment, Review of results with parent is a $250.00 charge.
A **comprehensive psychoeducational evaluation** of a child or adolescent typically includes an intake interview with parents or guardian (1 hr.), administration of all psychological tests (4-6 hrs.), a review of the results with the parents or guardians (1 to 1 /12hr.), and a written report (2-3 hrs.). A typical evaluation generally requires eight to nine hours of professional time **including** the written report. The total cost for an average evaluation depends on the time required to complete all portions of the assessment. **(Insurance Code 96101)**

A screening of **Attention Deficit-Hyperactivity Disorder** includes an initial interview to discuss presenting problems, behavioral strategies, family history, and the evaluation process, a school assessment, and an evaluation follow-up. The follow-up appointment will include a written report, interpretation of assessment results, and recommendations. **(Insurance Code 96101)**

- Initial Interview Fee: $175.00, due at time of meeting.
- School Assessment & Evaluation Follow-Up: Time needed and rates are ascertained after an Initial consultation. Dr. Milburn will make a determination after this discussion as to how much time she will need to render a diagnosis.

***Other services**:* $275.00 per hour for school observations, school meetings, and observations within the home setting.
(Insurance Code: 90882)
IQ Testing for area schools:
Metrolina Regional Scholars' Academy is at $175.00 per hour with a $25.00 Report Writing/Administrative Fee

☑ *I suggest you make out your check before each session begins, so that our time will be used best. I have found that this arrangement helps us to stay focused on our goals.*

☑ *Please make all checks payable to: Danielle Farese Milburn, Ph.D,*

☑ *Other payment or fee arrangements must be worked out before the end of our first meeting.*

If there is any problem with my charges, my billing, your insurance, or any other money-related point, please bring it to my attention. I will do the same for you. 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. I will also raise the matter with you 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 will pay 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, and so forth. 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 paying the fees we agree upon.

3. I am currently ***not*** participating on *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

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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: _____

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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: _____ Date of 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 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? _____

DEVELOPMENTAL HISTORY

PRENATAL

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

Were 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

Labor:	_____Natural	_____Induce	_____Duration (Hours)
Type:	_____Vertex (Normal)	_____Breech	_____Caesarean
Forceps:	_____High	_____Mid	_____Low
Birth Weight:	_____ lbs. _____ oz.		

COMPLICATIONS

At birth:

_____Cord around neck _____Hemorrhage (Excessive Bleeding)
_____Cord presented first _____Infant injured during delivery
_____Other:_____

After delivery:

_____Intensive Care _____Jaundice _____Oxygen Used
_____Infection _____Transfusion _____Cyanosis (turned blue)
_____Other:_____

DEVELOPMENTAL MILESTONES

AGE	AGE
_____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 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	_____	_____	_____

SCHOOL HISTORY

Current School: _____ Grade:_____
Phone Number: _____

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?
_____

Teacher(s) Name(s): _____
Teacher E-mail:_____

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?

_____
_____
_

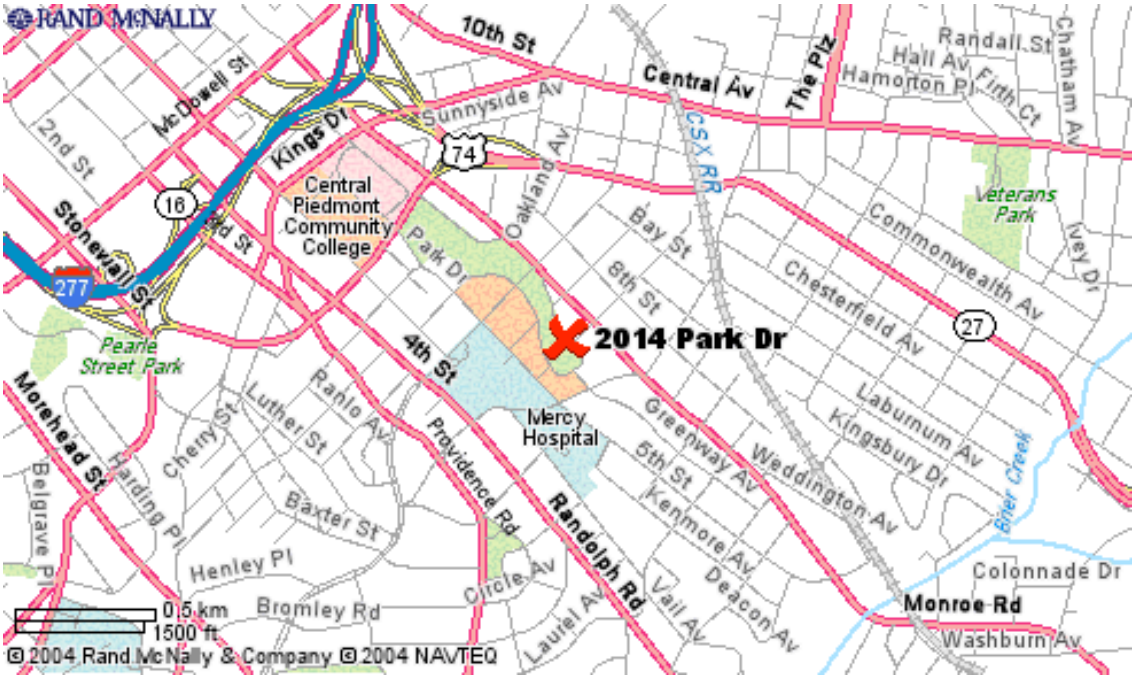
What does your child dislike most?

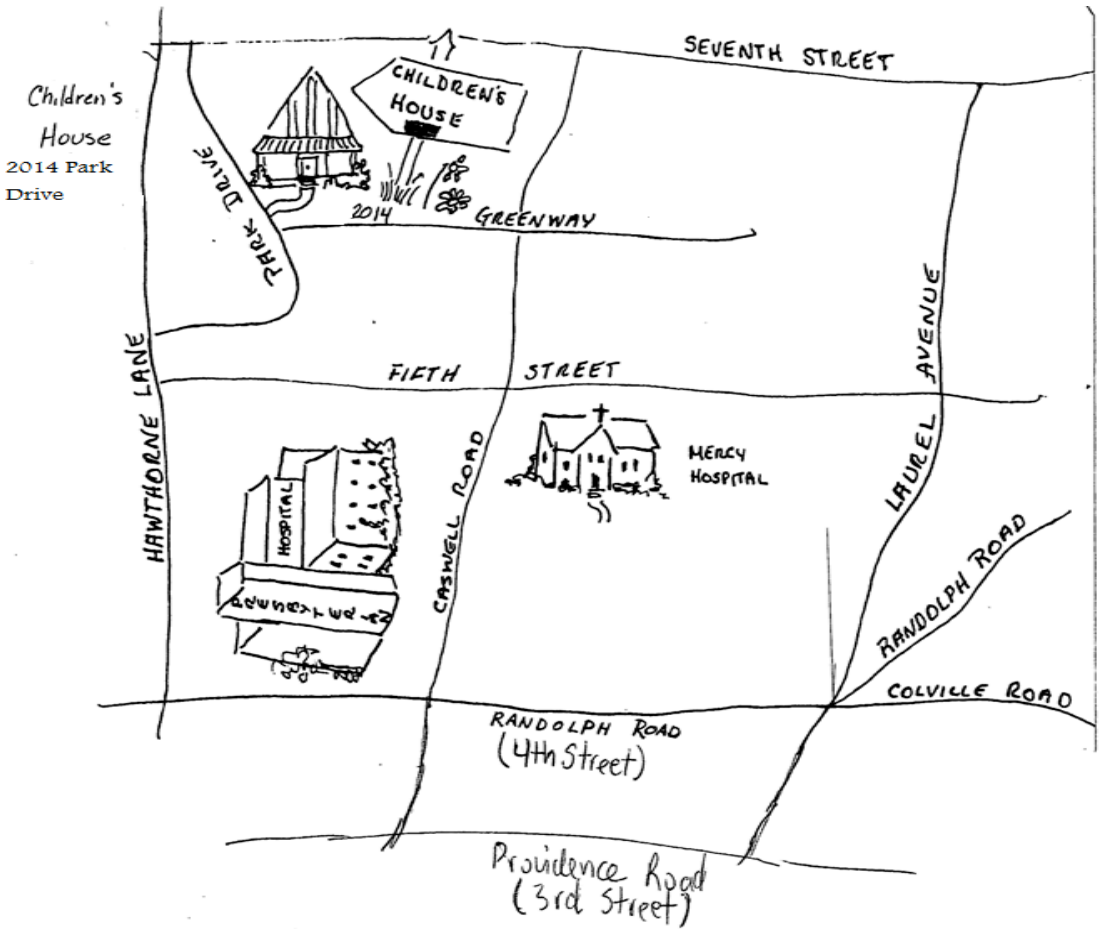
_____
_____
_

OTHER FACTORS

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

Our Charlotte office is located at:
The Children's House
2014 Park Drive
Charlotte, NC 28204
704-728-7364




Children's House
2014 Park Drive
SEVENTH STREET
CHILDREN'S HOUSE
2014
PARK DRIVE
GREENWAY
HAWTHORNE LANE
FIFTH STREET
LAUREL AVENUE
HOSPITAL
CASWELL ROAD
MERCY HOSPITAL
RANDOLPH ROAD
COLVILLE ROAD
RANDOLPH ROAD
(4th Street)
Providence Road
(3rd Street)