clarity
The speech, hearing, and learning center.
Discovering Potential
Empowering Communication
Transforming Lives

29 North Academy Street | Greenville, SC 29601
p 864.331.1400 f 864.331.1416
www.clarityupstate.org

Dear Parent(s)/Guardian(s):

We are excited that we will be working with you and your child soon. Prior to your child's upcoming appointment, we have several forms we would like for you to complete.

The following forms are included within this packet:

1. Background History Form
2. Consent to Test/Treat Form
3. Insurance Disclosure Form
4. What to Expect: Preparing For Your Child's First Visit
5. Directions to the Center for Developmental Services (CDS)

Please complete and return the **Background Information Form**, the **Consent to Test/Treat Form**, and the **Insurance Disclosure Form** to the following address ***as soon as possible***:

Clarity
Attention: Psychology and Learning Department
29 N. Academy Street
Greenville, SC 29601

If any questions or concerns arise as you complete these forms, please call **864-331-1402**.

We look forward to seeing you soon!

Sincerely,

Psychology and Learning

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Psychology and Learning Department

Background Information Form

The purpose of this questionnaire is to gather information about your child and family before your child's appointment. Your answers will allow us to plan the appointment specifically for your child. Do not worry if you do not have information to answer every question, as we will be discussing this further at your child's appointment. We appreciate your time and effort in completing this questionnaire.

Date: _____ Form Completed By: _____ Relationship to Child: _____

Child's Name: _____
(First) (Middle) (Last) ("Nick Name")

Date of Birth: _____ Sex: _____ Grade: _____

Name of School: _____ School District: _____

What are the most positive features about your child?

What are your primary concerns regarding your child/specific questions you would like addressed?

When did you first become concerned about your child?

How did you you hear about Clarity?

Family Information

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

_____ _____

Phone # _____ Phone # _____

Occupation _____ Occupation _____

Highest Grade Completed _____ Highest Grade Completed _____

Best email address to contact you:

Mother: _____

Father: _____

Child's Name _____ *Child's DOB* _____

Does your child have other parent(s)/stepparent(s)/primary caregivers? □ No □ Yes

If yes, please describe _____

With whom does this child live? _____

At what age did the child come into the current living situation? _____

If any immediate family members (for example, parent, sibling, etc.) are living elsewhere, please list:

Age	Sex	Relationship to this Child	Frequency of contact
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Language(s) other than English spoken in home: _____

Have there been any recent changes or stresses in the family/home? □ No □ Yes

If yes, please describe: _____

Early Developmental History

Was this child's mother under doctor's care during the pregnancy?

Did the pregnancy have any complications (for example, infections, illness, preeclampsia, injury, unusual emotional strain, gestational diabetes)? □ No □ Yes

If yes, please describe _____

During the pregnancy, did the mother take any medications or drugs? (other than vitamins/iron)? □ No □ Yes

If yes, please describe _____

During the pregnancy, did the mother drink alcoholic beverages or smoke cigarettes? □ No □ Yes

If yes, please indicate how much _____

Estimated length of pregnancy: _____ (weeks)

Type of labor onset: □ Induced □ Spontaneous Length of Labor:_____

Baby's Presentation: □ Breech □ Head

Type of delivery: □ Vaginal □ Cesarean

Type of anesthesia: □ Gas □ Spinal □ Local

Child's Name _____ *Child's DOB* _____

Did any complications occur during delivery (e.g., toxemia/eclampsia, fetal distress, etc.)? □ No □ Yes

If yes, please describe _____

Were any specialized procedures used (e.g., forceps, suction) during delivery? □ No □ Yes

If yes, please describe: _____

Birth weight: _____ lbs _____oz Apgar Scores, if known: _____ 1 min _____ 5 min _____10 min

What was the baby's condition following delivery? _____

Please describe any specialized treatment provided to baby following delivery: _____

_____

What was the mother's condition following delivery? _____

Length of hospital stay following delivery: _____ Mother _____ Baby

Check any of the following which occurred during your baby's first month of life:
□ Breathing Problems □ Convulsions □ Skin Rash □ Excessive Vomiting □ Injury

□ Jaundice (yellow) □ Infection □ Birth Defect □ Excessive Crying □ Feeding Difficulty

Were there any problems caring for this baby during their first year? □ No □ Yes

If yes, please describe: _____

Did you seek any services (such as, Baby Net, physical therapy, occupational therapy, speech therapy) in the first 3 years of this child's life? □ No □ Yes

If yes, please describe: _____

Please list the approximate ages your child reached the following milestones:

said first word: _____ used simple sentences: _____

sat up alone: _____ crawled: _____ walked alone: _____

toilet trained during day: _____ dry at night: _____

Health and Medical History

Who is your child's primary care physician? _____

		During What Ages? (e.g., 3 months to 2 years)
Has your child had any of the following?		
Convulsions, seizures, fainting spells	□ No □ Yes	_____
Vision or eye problems	□ No □ Yes	_____
Ear Infections	□ No □ Yes	
If yes, approximately how many ear infections has your child had? _____		_____
Have PE tubes been inserted?	□ No □ Yes	_____
If yes, how many times? _____		
Hearing problems	□ No □ Yes	_____
Allergies	□ No □ Yes	_____
If yes, what is your child allergic to? _____		
Any surgeries?	□ No □ Yes	
If yes, please describe _____		
Any serious accidents or injuries?	□ No □ Yes	_____
Any serious or chronic illnesses?	□ No □ Yes	_____
Was your child ever hospitalized overnight?	□ No □ Yes	_____
If yes, when and why? _____		
Any history of lead poisoning or other toxin exposure?	□ No □ Yes	_____
Any reaction to an immunization?	□ No □ Yes	_____
Has your child ever been given a diagnosis (e.g., ADHD)?	□ No □ Yes	
If so, please state diagnosis? _____		

When was your child's last medical check-up? _____

Please list any current health concerns (for example, eating problems, sleeping problems, bedwetting, stomachaches, headaches, weight gain, anxiety, depression)? _____

_____

Child's Name _____ *Child's DOB* _____

Please list current medications, including over-the-counter:

Name of medication	Dose/frequency	Length of time on medication	Name of Prescribing Physician

Does or has your child received any of the following services? Please describe:

Speech/language therapy □ No □ Yes : _____

Occupational therapy □ No □ Yes : _____

Physical therapy □ No □ Yes : _____

Counseling □ No □ Yes : _____

Tutoring □ No □ Yes : _____

Educational History

What schools has your child attended? (please list in chronological order beginning with nursery/preschool)

_____

_____

Has your child ever repeated a grade? □ No □ Yes Which? _____ Reason? _____

What are your child's academic strengths? _____

□ Reading phonics/decoding □ Reading Comprehension □ Math □ Written Work

□ Study Skills □ Organizational □ Listening/Understanding Directions or Questions □ Other

In what areas does your child have more difficulty? _____

□ Reading phonics/decoding □ Reading Comprehension □ Math □ Written Work

□ Study Skills □ Organizational □ Listening/Understanding Directions or Questions □ Other

Are you worried when you compare your child to other children his/her age academically? □ No □ Yes

If yes, please describe _____

Child's Name _____ *Child's DOB* _____

Does your child like to attend school? □ No □ Yes

If no, please describe _____

Is homework completion a concern? □ No □ Yes

If yes, please describe _____

Has the school contacted you about behavior concerns? □ No □ Yes

If yes, please describe _____

Does your child receive extra school help? □ No □ Yes If yes, please indicate:
□ Tutoring □ RtI □ 504 □ IEP/Special Education □ Counseling □ Other (Describe)
□Reading
□Math

If your child has had an IEP/received special education services:
Why were these services initiated (e.g., speech, reading difficulty)? _____

When did he/she first begin receiving services? _____

What services does/did he/she receive? _____

Have any services been discontinued and if so, which and when? _____

Has your child ever had any testing done by the school system? □ No □ Yes

If yes, please describe _____

Have you ever sought testing elsewhere? □ No □ Yes

If yes, please describe _____

Social, Emotional, and Behavioral History

Please list the things your child does well: _____

_____

What does your child enjoy doing in his/her free time? _____

Do you have any concerns for your child's social development? □ No □ Yes

If yes, please describe _____

How is your child getting along with siblings and parents/guardians? _____

How is your child getting along with other children his/her age? _____

What do you think of your child's closest friends/peer group? _____

Child's Name _____ *Child's DOB* _____

Do you have concerns for your child's emotional functioning? □ No □ Yes

If yes, please describe _____

Are there behavior problems at home? □ No □ Yes

If yes, please describe _____

Family Medical, Emotional, and Learning History

Is your child adopted? □ No □ Yes

Biological mother's age and general health: _____

Biological father's age and general health: _____

Is there a family history of any of the following concerns?			If yes, list who has/d these concerns
Learning Difficulties	□ No	□ Yes :	_____
Reading	□ No	□ Yes :	_____
Written Language	□ No	□ Yes :	_____
Mathematics	□ No	□ Yes :	_____
Attention Problems	□ No	□ Yes :	_____
Hyperactivity/Impulsivity	□ No	□ Yes :	_____
Anxiety Problems	□ No	□ Yes :	_____
Autism Spectrum Disorder	□ No	□ Yes :	_____
Intellectual Disability	□ No	□ Yes :	_____
Depression	□ No	□ Yes :	_____
Bipolar Disorder	□ No	□ Yes :	_____
Schizophrenia	□ No	□ Yes :	_____
Language/Speech Delay	□ No	□ Yes :	_____
Any genetic syndrome	□ No	□ Yes :	_____
Conduct Problems	□ No	□ Yes :	_____
Drug/Alcohol Problems	□ No	□ Yes :	_____
Seizure Disorder	□ No	□ Yes :	_____
Motor or Vocal Tics	□ No	□ Yes :	_____

			If yes, list who has/d these concerns
Thyroid Problems	□ No	□ Yes :	_____
Diabetes	□ No	□ Yes :	_____
Hearing Loss	□ No	□ Yes :	_____
Visual Problems	□ No	□ Yes :	_____
Muscular problems/weakness	□ No	□ Yes :	_____
Other (Please specify)	□ No	□ Yes :	_____

Additional Comments/Concerns (If needed, please use the backside of this page.)

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INFORMED CONSENT FOR EVALUATION AND THERAPEUTIC SERVICES

Welcome to the Psychology and Learning Department at Clarity. This agreement contains important information about our services and your rights and responsibilities as a client. It is important that you read this document carefully before participating in the evaluation and/or therapeutic services. After you have read this document, please sign your name on the last page to accept the terms of this document.

CONSENT FOR SERVICES

As a legally consenting individual, I agree to permit the clinicians of the Psychology and Learning Department at Clarity to provide therapeutic services (such as, learning therapy, coaching, or counseling) and/or conduct a comprehensive psycho-educational/psychological evaluation on myself or my child, as applicable.

I understand that therapeutic services may be provided by a person who holds at least master's degree and has received specialized training in learning disabilities, special education, reading, psychology, counseling, elementary education with concentration in special education or reading, secondary education with concentration is special education or reading. When required by law due to the nature of services rendered (that is, coaching or counseling), services are provided by a licensed psychologist, a licensed professional counselor, post-doctoral fellow under the direct supervision of a licensed psychologist, or psychology trainee under the direct supervision of a licensed psychologist.

I understand that evaluations are provided by a licensed psychologist, post-doctoral fellow, or psychology trainee under the direct supervision of a licensed psychologist. A post-doctoral fellow is an individual who has a doctoral degree in psychology and is in the process of completing the year-long supervisory period that is required prior to becoming a licensed psychologist. A psychology trainee is an individual who has not yet obtained a doctoral degree in psychology but is obtaining training required for the completion of a doctoral degree in psychology.

I understand that participation in therapeutic services and/or an evaluation is entirely voluntary and I or my child can withdraw consent at any time without penalty. However, I understand that Clarity may be unable to provide feedback of the test results if testing is terminated, and that I will still be responsible for payment of any testing, scoring, and evaluation time provided up until termination.

CONFIDENTIALITY

I understand that communication between a client and clinician are protected by both federal and state law. The results of this evaluation will be confidential and will not be released in an individually identifiable form without my prior consent unless required by law. I understand that in many situations, Clarity can only release information about this evaluation to others if I sign a written authorization form that meets certain legal requirements imposed by state and federal privacy regulations. Clarity will follow applicable state laws and professional standards in the storage, maintenance, retention, and destructions of clinical records. Please see the HIPAA Privacy Notice, which explain HIPAA and how it applies to your personal health information in greater detail.

I agree that for training purposes, evaluation sessions may be observed by supervisors or trainees (such as, a postdoctoral fellow). I also authorize the use of clinical case discussion and review of records for the purpose of training or consultation with other providers within Clarity, who are also legally bound to keep the information confidential.

I understand that Clarity must be in compliance with child abuse reporting laws and court mandated rulings regarding release of confidential information or any provision of psychological services. Situations in which Clarity is legally obligated to take action and may reveal some personal health information including, but are not limited to, filing a report with the appropriate government agency when they have reasonable cause to suspect abuse, abandonment, or neglect of a child under 18 or a vulnerable adult, protective action if it is believed that a client represents a clear and immediate threat to another person or themselves, or receipt of a subpoena from a court proceeding.

AUTHORIZATION FOR INFORMED CONSENT FOR PSYCHO-EDUCATIONAL EVALUATION

I fully understand and accept the terms of this consent.

_____ _____
Signature of Client (representative or parent/guardian if a minor) Date

_____ _____
Print Name Relationship to Client (if not self)

_____
Client Name

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INSURANCE DISCLOSURE

Please read and sign the following. If you have any questions about this form, please call (864) 331-1402.

I understand that I am responsible for filing insurance for psychology and learning services. I will be given appropriate paperwork for the purpose of filing. I understand that Clarity is not contracted with any insurance company for psychology and learning services. I am responsible for all costs associated with these services up front.

For our Psychology and Learning services payment is required at the time of service.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Patient Name Patient's Date of Birth

Deposit Acknowledgement:
I acknowledge that if I cancel my child's evaluation within (2) weeks of the appointment, and choose not to reschedule the appointment, the deposit will be forfeited. (This policy applies to cancelled appointments – not appointments that must be rescheduled due to illness or family emergency.) I further acknowledge that I or my child will be allowed only one reschedule before my deposit is forfeited (does not apply if Clarity Staff causes the reschedule).

_____ _____
Signature of Parent/Guardian Date

_____ _____
Patient Name Patient's Date of Birth

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What to Expect

When your child has been scheduled for an evaluation appointment, we have a few suggestions to help make the experience a more positive one.

1. It has been helpful for many parents to explain the visit as a "Learning Check-Up".
2. Tell a younger child that he or she will be doing "learning activities" like listening, solving puzzles, and reading. Please do *not* set the expectation that your child is coming to play games. Although many children do enjoy "showing off" what they have learned, your child will be taking challenging tests and over-selling the appointment as a "fun" thing may prove counter-productive.
3. Tell a younger child that this is *not* a physician appointment; no one will use needles, etc.
4. Tell a younger child that he or she may be asked to wear earphones (for hearing screening) and look through special binoculars (for vision screening).
5. For an older child who expresses concern over the stigma of an evaluation or fear that having this assessment means that he or she is "stupid" or "crazy", you may wish to reassure him/her that everyone deals with periodic challenges. Coming in for an evaluation does not mean he or she has done anything wrong; rather, this appointment is an opportunity to find out his or her strengths and weaknesses and perhaps identify some new ways of dealing with things to make home, school, and/or social life go more smoothly.
6. If your child's appointment is longer than two hours, it will probably be helpful to bring a snack and a drink.
7. If your child's appointment is scheduled to last four or more hours, an hour break will be scheduled for lunch.
8. Tell your child that it is "OK" if he or she doesn't know everything.
9. Parents' undivided attention is needed during the separate *feedback session*. It is generally considered best <u>not</u> to have your child in attendance during that time (the exception would be a college-bound high school senior or college-age student).
10. High school age clients are encouraged to attend an additional, separate feedback session for approximately 20 minutes during after school hours following the parent feedback appointment. The purpose of this session is to broadly go over the major findings (e.g., talk about strengths and weaknesses, not specifics, like IQ score) and, if appropriate, to explain why a diagnosis was made or certain recommendations given. There is no separate charge for this.
11. ***PLEASE MAIL COPIES OF ANY PAST EVALUATION REPORTS, STANDARDIZED TEST SCORES, AND REPORT CARDS <u>BEFORE</u> THE APPOINTMENT, IF POSSIBLE.***
12. We make every effort to get you the complete evaluation report as quickly as possible; however, given the length and detail of our reports, **it can take *<u>up to 4 weeks</u>* from the date of the <u>feedback</u> appointment for you to receive the dictated report in the mail**. For time sensitive matters, we often can provide brief, summary letters to physicians, schools, etc. in advance of the full report to facilitate interventions or placement decisio

Directions to the Center for Developmental Services

From Anderson or Spartanburg:

- Take I-85 to Exit 42 in Greenville (I-185)
- Take I-185 into Greenville (2.4 miles)
- I-185 becomes Mills Ave./29
- Drive 1 mile on Mills Ave. to Augusta St./25
- Turn left onto Augusta St.
- Drive about 1 mile to intersection of Pendleton, River, Main, and Augusta Streets -- veer left onto River St.
- Turn left onto Camperdown Way
- Turn right onto Academy St.
- Cross McBee Ave. and Washington St.
- Building is on the left on the corner of Hampton and Academy Streets

From Easley:

- Take U.S. 123 N. to Greenville
- Becomes Easley Bridge Highway/U.S. 123 N.
- Cross Pendleton St. -- becomes S. Academy St./U.S. 123 N.
- Drive about 3 miles -- cross Washington St.
- Building is on the left on the corner of Hampton and Academy Streets

From Greer or Spartanburg:

- Take Wade Hampton Blvd./U.S. 29 S. to Greenville
- Veer left onto Church St.
- Turn right onto Academy St.
- Cross Buncombe St. -- drive one block
- Building is on the right on the corner of Hampton and Academy Streets

From Laurens and the Golden Strip area:

- Take I-385 into Greenville
- Cross Church St./U.S. 29 (pass the BI LO Center) -- street name becomes Beattie Pl.
- Cross Main St. -- street name becomes College St.
- Turn left onto Academy St.
- Building is on the right on next block on the corner of Hampton and Academy Streets

From Travelers Rest:

- Take Poinsett Highway/U.S. 276/U.S. 25 south to Greenville
- Becomes Rutherford St.
- Turn left onto Buncombe St.
- Drive a half mile -- turn right onto Academy St.
- Building is on the right on the next block on the corner of Hampton and Academy Streets