LSU Health NEW ORLEANS
School of Allied Health Professions

HUMAN DEVELOPMENT CENTER
BUILDING CAPACITY • INSPIRING CHANGE

ASDID Clinic Application Packet

All fields marked with * are required.

Patient Full Name*

Introduction

Thank you for your interest in the Autism Spectrum Disorders Interdisciplinary (ASID) Clinic at the LSUHSC Human Development Center. The purpose of the ASDID clinic is two-fold:

1. To provide outstanding services to families of children suspected of having autism spectrum disorder (ASD).
2. To provide high-quality information, training, and supervision to pediatric medical residents, graduate students, professionals, and families about best practices in family partnerships and interdisciplinary teaming and evaluations.

The clinic works together to engage in best practices for ASD assessment, diagnosis, and support for children and their families.

In addition to providing a much-needed service to the community through a comprehensive evaluation process for ASD, the ASDID clinic serves as a training experience for students and professionals in a number of disciplines. Participating disciplines may include audiology, early childhood intervention, medicine/pediatrics, occupational therapy, physical therapy, psychology, public health, special education, and speech-language pathology.

Note: Throughout this packet, you will be called the **Patient's Representative,** or **Representative** for short.

New Patient Registration

All fields marked with * are required.

Patient Full Name*

Patient Date of Birth*

Patient Street Address*

City* State*

ZIP*

Phone Number

Representative's Full Name*

Representative's E-mail Address*

Representative's Street Address*

City* State*

ZIP*

Representative's Relationship to Patient (select one):

☐ Biological Parent
☐ Adoptive Parent
☐ Foster Parent
☐ Guardian
Other: _____

_____
Emergency Contact Full Name

_____
Emergency Contact Phone Number

Emergency Contact's Relationship to Patient (select one):

☐ Biological Parent
☐ Adoptive Parent
☐ Foster Parent
☐ Guardian
Other: _____

For Office Use Only

_____
Appointment Date

_____
Account Number

_____
Clinician

_____
Referring Provider

ASDID Clinic Intake Form

All fields marked with * are required.

Please complete this form to the best of your ability. We recognize that you may not have the answers to all questions. If you feel that there is not enough room or that you would like to elaborate further about a particular topic, please feel free to include it at the space provided at the end of the packet. All information requested in this form is important and will allow us to provide you with the most accurate diagnosis and care plans. Thank you for taking the time to complete it. If you have questions about completing this form or the process for the clinic, please contact Kelly Sommers at ksomme@lsuhsc.edu.

Basic Information and Healthcare Provider

☐ Patient's parents are divorced or separated

If patient's parents are divorced or separated, do they have joint or sole responsibility for the child? (Check one)
☐ Joint
☐ Sole

If sole, which parent? _____

With whom does the child reside?

Household 1

Household 1 is the primary household if the child does not spend equal amounts of time between two primary households.

_____
Percent Time (50%-100%)*

_____
Full Name of Parent/Guardian #1*

_____
Full Name of Parent/Guardian #2

Names, ages, and relationship to child of all other individuals in the home:

_____
_____
_____
_____
_____
_____
_____

Household 2

Percent Time (1%-50%)

Full Name of Parent/Guardian #1

Full Name of Parent/Guardian #2

Names, ages, and relationship to child of all other individuals in the home:

☐ Both parents are aware that services are being requested from LSUHSC ASDID clinic

If child has a guardian *ad litem,* please provide their name

Names and ages of siblings not living with the child:

Primary language if not English

Percent time child is exposed to non-English languages

Race (from US Census List, check one):
☐ White
☐ Black or African-American
☐ American Indian or Alaskan Native
☐ Asian
☐ Native Hawaiian or Pacific Islander
More than one race (clarify) _____
Other (clarify) _____
☐ Prefer not to answer

Hispanic refers to cultural identification with Spain or Spanish-speaking countries. An individual of any race can be Hispanic.

Ethnicity
☐ Hispanic
☐ Non-Hispanic
☐ Prefer not to answer

_____
Primary Care Physician*

_____
Clinic Name*

_____
Phone Number*

_____
Street Address

_____
City* State*

_____
ZIP*

☐ Patient is enrolled in school (including home school)

_____
School Name

_____
Street Address

School City*

State*

ZIP*

What are your primary patient concerns?

What do you hope to gain from the evaluation services provided by the ASDID Clinic?

Patient Consent for Treatment

I do hereby voluntarily consent to such treatment as is deemed necessary by the clinician. I hereby release Louisiana State University Health Sciences Center and its personnel from any responsibilities resulting from illness, ill effect, or reaction from the treatment ordered by my physician.

Patient Guarantee and Authorizations

In consideration for and to cause Louisiana State University Health Sciences Center School of Allied Health Professions Clinics to treat _____ (Patient Full Name) as a private patient, the undersign unconditionally guarantees of all cost charges and expenses of the Louisiana State University Health Sciences Center School of Allied Professions Clinics to apply for benefit on my behalf for covered services rendered by LSU School of Allied Health Clinics, and request all payments be made to "LSUHSC." Furthermore, I understand and agree any unpaid balance not covered by my insurance policy will be paid directly by me.

Insurance forms are mailed to (check all that apply):
☐ Employer
☐ Insurance Company
Other (please specify): _____

_____

Representative's Signature* Date*

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (Representative's Full Name), acknowledge that I have received a copy of the Notice of Privacy Practices of LSUHSC New Orleans on this date.

The Notice of Privacy Practices is attached to this document at the end. It is not necessary to include it when mailing the packet.

_____

Representative's Signature* Date*

Consent to Photograph/Videotape/Audiotape

I give permission to Louisiana State University Health Sciences Center (LSUHSC) to photograph, videotape, or audiotape me and/or my child, _____ (Patient Full Name), during evaluation and treatment sessions. I understand that these may be used for teaching, professional presentations or for publication. Photographs and tapes will be the property of the department and will be held in confidence. In some instances, the name of you or your child may be used.

Please indicate any restrictions below or strike out and initial any exclusions.

_____

Representative's Signature* Date*

Authorization of Release of Protected Health Information (1 of 3, From PCP)

Authority to Release Protected Health Information

I hereby authorize _____ (Clinic Name) to release information from the records of _____ (Patient Name) and provide such authorization to **LSUHSC Autism Spectrum Disorders Interdisciplinary Clinic.**

Information to Be Released

Covering the Periods of Health Care from _____ (Birth Date) to _____ (One Year from Current Date)

- Complete health record
- History and physical exam
- Diagnosis and treatment codes
- Consultation reports
- Developmental and sensory screenings

Purpose of the Requested Disclosure of Protected Health Information

The purpose is to support diagnostic evaluation and intervention planning.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

☐ I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release.*
☐ I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.*

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to **Tiffany Williams, MSW, RSW** at **LSUHSC ASDID Clinic, 411 South Prieur Street, New Orleans, LA 70112.** Unless revoked, this authorization will expire after the following date or event: **Follow-up meeting with parent or guardian approximately one month after appointment**

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclo-

sure by the recipi ent and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge LSUHSC-NO and its officers, directors, employees and students of any liability and the undersigned will hold them harmless for complying with this Authorization.

Representative's Signature* Date*

Authorization of Release of Protected Health Information (2 of 3, From EarlySteps)

Authority to Release Protected Health Information

I hereby authorize **Louisiana EarlySteps** to release information from the records of _____ (Patient Name) and provide such authorization to **LSUHSC Autism Spectrum Disorders Interdisciplinary Clinic.**

Information to Be Released

Covering the Periods of Health Care from _____ (Birth Date) to _____ (One Year from Current Date)

- Complete health record
- History and physical exam
- Diagnosis and treatment codes
- Consultation reports
- Developmental and sensory screenings

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Representative's Signature* Date*

Authorization of Release of Protected Health Information (3 of 3, From School)

Authority to Release Protected Health Information

I hereby authorize _____ (School Name) to release information from the records of _____ (Patient Name) and provide such authorization to **LSUHSC Autism Spectrum Disorders Interdisciplinary Clinic.**

Information to Be Released

Covering the Periods of Health Care from _____ (Birth Date) to _____ (One Year from Current Date)

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