

Jill Claridge, Ph.D.

Educational Diagnostician & Consultant

920 Crest View Drive Bedford, TX 76021

817-788-5186 FAX 817-796-1150

jill@jclaridgephd.com www.jclaridgephd.com

Hello!

I look forward to meeting you. Enclosed are directions to my home, a resume, and forms for you to complete. There are two pages of forms for one or more teachers to complete if you are attending school/university/college. I would like to see report cards, notes from teachers, previous testing, etc...anything that would help document the difficulties you are having. I'd like to have all this information prior to testing -- even one day prior is fine.

The fee is \$975.00 and the fee is due on the day of testing. I DO NOT accept or work with insurance. I accept check, cash, and credit and debit cards. In order to pay with debit/credit cards you must go to the website: www.jclaridgephd.com and click the payment tab. The testing takes 3 to 4 hours. If you are currently taking any medications for attention, please take them on the test date. If you think of any questions, please let me know. I look forward to working with you.

Best wishes,



Jill Claridge, PhD

Cancellation policy: Please give at least 24 to 48 hours notice so I may contact a family on the waiting list. If there is a “fail to show” for an appointment, 1) there is a \$100 appointment lost fee that will be billed to you; and 2) when you re-schedule the entire testing fee is due up-front immediately upon re-scheduling the appointment. If the testing fee is not received within five days of the date of re-scheduling the appointment, the appointment will be cancelled. Thank you for understanding the need to have this policy.

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Directions

From Coppell/Grapevine:

Take 121 South past Glade, Cheeksparger, Harwood and continue towards Ft. Worth on 183. Take second exit, which is Brown Trail. Go north or right on Brown Trail pass LD Bell High School. Go one mile to light at Harwood and turn right or east on Harwood. Second light take a left or north on Shady Brook. In about 7 blocks Shady Brook dead ends to my street: Crest View. Turn left or west and go to fourth home on left. **“Feisty”** Postman – avoid parking in front of **his** mailbox!

OR

Take Grapevine Hwy/26 south to Brown Trail (at Braums). Take Brown Trail left to light at Cheeksparger. Left on Cheeksparger pass Tara Village to first street on right – McClain (take right). First street on right past Cummings/stop sign (past apts) is Crest View Drive. Right on Crest View to 920 – in the second block – address on mail box - **“Feisty”** Postman – avoid parking in front of **his** mailbox!

From Ft. Worth:

Go towards the DFW airport. Airport Freeway (183) to Brown Trail exit, which you take north past L.D. Bell High School (coming from Ft. Worth take Brown Trail left). Go one-mile north on Brown Trail to Harwood (there is a “7-11” at this corner). Take Harwood right or east. Take the third street, Shady Brook, left. Shady Brook dead-ends to my street Crest View. Left on Crest View – 920 is fourth home on left. **“Feisty” Postman** – avoid parking in front of **his** mailbox! (P.S. There is a street named “Clear View” a few blocks before my street – don’t turn there!)

From Dallas / Arlington:

Go towards Fort Worth on Airport Freeway (183) to Brown Trail exit, which you take north (right) past L.D. Bell High School. Go one-mile north on Brown Trail to Harwood (there is a “7-11” at this corner). Take Harwood right or east. Take the third street, Shady Brook, left. Shady Brook dead-ends to my street Crest View. Left on Crest View – 920 is fourth home on left. **“Feisty” Postman** – avoid parking in front of **his** mailbox! (P.S. There is a street named “Clear View” a few blocks before my street – don’t turn there!)

Looking forward to seeing you! Jill Claridge

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FAMILY INFORMATION

Referred by: _____

NAME (person to be tested) _____ BIRTHDATE _____

PARENT NAME _____

ADDRESS _____ CITY/ZIP _____

PHONE _____ CELL _____ WORK _____

E-MAIL _____

FAX NUMBER _____

REFERRAL INFORMATION

What concerns prompted you to call for testing?

HEALTH HISTORY

Please give details of any medical problems, birth history concerns or serious injuries :

Please list any allergies you may have (food, medications, respiratory allergies, asthma):

Current stressors: _____

Please list medications you are presently taking: _____

Physician's Name: _____

REVIEW OF SYSTEMS

Do you have any history of:

	Yes	No		Yes	No
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Staring episodes	<input type="checkbox"/>	<input type="checkbox"/>	Sleep difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Motor/vocal tics	<input type="checkbox"/>	<input type="checkbox"/>	Wears glasses	<input type="checkbox"/>	<input type="checkbox"/>
Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Significant weight loss/gain (circle)	<input type="checkbox"/>	<input type="checkbox"/>

Date of most recent vision (and hearing) screening and results: _____

FAMILY/SOCIAL HISTORY

Any family history of:

	Yes	No		Yes	No
Learning disabilities	<input type="checkbox"/>	<input type="checkbox"/>	Slow learning	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	Genetic Syndromes	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Is your child adopted?	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive compulsive		

BEHAVIOR CHECKLIST (Check items that may describe you)

Doesn't seem to listen	<input type="checkbox"/>	Often angry or resentful	<input type="checkbox"/>
Is easily distracted	<input type="checkbox"/>	Seems sad, blue, or depressed (circle one)	<input type="checkbox"/>
Lies /steals (circle one)	<input type="checkbox"/>	Loss of interest in daily activities	<input type="checkbox"/>
Interrupts/ intrudes on others	<input type="checkbox"/>	Learning difficulties	<input type="checkbox"/>
Excessively active	<input type="checkbox"/>	Anxious	<input type="checkbox"/>
Talks about a topic excessively	<input type="checkbox"/>	Suicidal statements, plans, attempts	<input type="checkbox"/>
Picks at nails, skin, etc.	<input type="checkbox"/>	Obsessive compulsive behaviors	<input type="checkbox"/>
Uncoordinated	<input type="checkbox"/>	Excessive worry	<input type="checkbox"/>
Self-injuries	<input type="checkbox"/>	Avoids social activities	<input type="checkbox"/>
Argues with others	<input type="checkbox"/>	Poor organizational skills	<input type="checkbox"/>
Trouble interacting with others	<input type="checkbox"/>	Acts as if in 'own world'	<input type="checkbox"/>

Difficulty sustaining attention or concentration on home/school tasks	<input type="checkbox"/>
Repetitive behaviors (ordering, checking, repeating)(explain)	<input type="checkbox"/>
Troubled by recurrent or persistent thoughts (explain)	<input type="checkbox"/>
Difficulty understanding/following others' conversations	<input type="checkbox"/>
Lacks empathy (understanding of how others feel)	<input type="checkbox"/>

Explain the above and any others:

Name _____

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WORK / SCHOOL INFORMATION

Where do you work or go to school? _____

Position & job responsibilities? Or subject major? _____

Are you able to succeed easily at work/ in school?

Has there been a recent changes in your work or school performance?

Problems with any specific areas _____

What are your strengths: _____

What are your weaker areas? _____

Comments: _____

Signature _____

Date _____

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Adults

**GO ONLINE TO COMPLETE
CONNERS' ADULT RATING SCALE**

Go to: www.mhsassessments.com

and login with the code and password that appear below.

It takes about 10 minutes to do this.

Code: **3059-001-456**

Password: **claridge**

******* Important** not to leave any questions blank as this will cause the entire report to be “invalid”.

If you have any questions please feel free to contact me.

Jill Claridge, PhD

NOTICE OF PRIVACY PRACTICES (MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1998 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by me in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information.

I may use and disclose your records only for each of the following purposes: treatment, and payment.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include sending records to your physician.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment to you.

I may contact you to provide appointment reminders or information about treatment alternatives or other related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to me.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from me by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from me upon request.

I am required by law to maintain the privacy of your protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of my Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with my office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of my office. I will not retaliate against you for filing a complaint.

Please contact me for more information: For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain reimbursement to parent from third-party payers.
- Conduct normal healthcare operations such as quality assessments and clinician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

Client's Name: _____
Relationship to client: _____
Signature: _____
Date: _____

**

REQUEST TO SEND REPORT TO OTHER PERSONS

I (We) give my (our) permission to Jill Claridge, Ph.D. to send a copy of my educational evaluation report to my (our) attention at the following:

Reports are sent via E-Mail only. Please provide an e-mail for any additional individual(s) you wish to receive a copy of the report.

Also send report to: _____

**

Name/Signature _____ Date _____