



CONNERS SCALE REQUEST FORM

Today's Date: ____/____/____

Child's Name: _____ Date of Birth: ____/____/____

Primary Physician: Hamm Loeb Nagy Speropoulos Gatz Allen Steele

At Leawood Pediatrics, we are committed to providing thorough and timely assessments to support the health and well-being of your child. If your physician recommends completing the Connors Scale assessment, please note the following process:

- 1. **Assessment Fee:** There is a flat fee of \$50 for the Connors Scale assessment. This fee covers the cost of processing and reviewing the forms.
- 2. **Payment Process:** The \$50 fee must be paid before the forms are provided.
- 3. **Form Completion:** After receiving the forms, you will be given instructions on how to complete them. You can return the completed forms to us via email, our secure patient portal, or in-person.
- 4. **Next Steps:** Once the forms are submitted, our team will review them, and your physician will discuss the results with you during your next visit or follow-up appointment.

Please check one of the following:

- I will pay with card or check today - CHECK#: _____ Employee Initials: _____
 Select Card: VISA MC DISC AMEX
 Card No. _____ Exp. Date _____ Sec. Code _____
- Please charge my card on file. I am aware I am responsible for my card on file being current
 - DATE CARD CHARGED: ____/____/____

Printed Parent/Guardian Name: _____ Parent/Guardian Signature: _____

(or Patient if 18 yrs or older)

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Please complete this paperwork request form in black ink only.

You submit your request via:

Email medicalrecords@LeawoodPediatrics.com
 Fax 913.948.9128
 Mail/Person 5401 College Blvd, Ste 101, Leawood, KS 66211

-----OFFICE USE ONLY-----

Payment posted to account: ____/____/____ in the amount of \$ _____ Employee Initials: _____