Please return to Intake@ABAUnlimitedLLC.com.

Intake

Today's Date: _____

Patient Information:

_____ _____ _____

Last Name First Name DOB

Sex: M F Phone: _____

_____ _____ _____

Street Address City, State Zip

Insurance Subscriber's Information

Last Name:_____ First Name:_____ DOB:_____

_____ _____

Sex: M F SSN Phone

Street: _____ City, State:_____ Zip:_____

(If different from above.)

_____ _____

Employer Insurance

_____

Email Address

Medical History

Diagnostic Physician :_____ Telephone:_____

Diagnosis:_____ Date Diagnosed:_____

_____ _____ _____

Street Address City Zip

IFSP? (Medicaid Only) Y N Diagnosis Level: 1 2 3

Medication (Name and Dosage):_____

IEP: Y N 504 Plan: Y N Date of most recent IEP: _____

Other Therapies your child receives:

OT: _____ Days per week: _____ Duration: _____
(Name)

Speech: _____ Days per week: _____ Duration: _____
(Name)

PT: _____ Days per week: _____ Duration: _____
(Name)

Days/Hours Requested
(Please note that this request is your ideal schedule but that no guarantees are made that we will be able to adhere to this schedule.)

M:	9AM-12PM	1PM-4PM	Th:	9AM-12PM	1PM-4PM
T:	9AM-12PM	1PM-4PM	F:	9AM-12PM	1PM-4PM
W:	9AM-12PM	1PM-4PM			

Main Concerns

Please list any concerns the child may have at home or in the community. This may include, but is not limited to, sensitivity (i.e. oversensitive to noises, oversensitive to certain material or texture of food), behaviors, communication, social skills and play skills. Additionally, provide any special accommodations that would help staff to better support your child's progress.

Consent for Billing

I hereby consent to treatment by, and authorize insurance benefits to be paid directly to, ABA Unlimited, LLC. I agree that I am responsible to pay 1) for services not covered by my insurance company (where applicable), 2) co-payments and deductibles, and 3) any expense associated with the collection of a debt owed to them by me (i.e. attorney's fees, court costs, or collection agency fees). I also consent to the release of pertinent medical information to my insurance carrier(s) for processing healthcare claims.

_____ _____

(Signature) (Date)

Consent for Treatment

I, _____ (name), hereby consent for ABA Unlimited, LLC, to provide Applied Behavior Analysis services for my child _____ (name). I understand that that ABA Unlimited, LLC will create a unique plan for my child, based on the principles of behavior change, to create long-lasting outcomes that will enhance his/her quality of life. Therapy is regulated by laws, ethics, and your rights as a client/guardian of a client. I understand that all information shared will follow HIPAA (Health Insurance Portability and Accountability Act), the federal laws that govern how medical professionals and insurances must maintain confidentiality with regards to treatment, billing, and sharing information between providers. I understand that communication with the technicians and supervisory staff is confidential and will not be shared with anyone else unless written and signed permission is given for its release. I understand that participation in ABA services is voluntary and may be withdrawn at any time without penalty. I understand that there are both benefits and risks of ABA services. The benefits include, but are not limited to, improved communication, socialization, and reduction of behaviors interfering with community and family life participation. The risks include, but are not limited to, emotional distress for the client or family when working on interfering behaviors, that skill acquisition is based on the client and may be slower or faster for each person, and that behavior change is often a slow process that involves a lot of work and that inconsistent therapy can often exacerbate behaviors of concern. I understand that I may request a referral to another provider at any time if I am unsatisfied with treatment progress. I understand that BCBAs, BCaBAs, and RBTs are mandated reporters required by law to report instances of abuse and neglect or suspicions of abuse and neglect.

_____ _____

(Signature) (Date)

Cancellation Policy

Consistent therapy is extremely important for your child.

1. If the client or a family member is ill or has a different appointment that must take place during your child's scheduled therapy time, please give 24-hour notice for rescheduling. Please call the office number and speak to an administrator or leave a message. Sometimes it is necessary to cancel therapy appointments due to emergency circumstances.

2. A "No call/no show" is defined as when the provider shows up at the client's home to provide services, but the client isn't home. The provider will call the family to get in touch with them but will not wait longer than 15 minutes. Two "no call/no shows" within a six-month period will result in a mailed reminder of the cancellation policy. A third "no call/no show" within a six-month period will result in termination of services. Please be advised that ABA Unlimited, LLC reserves the right to terminate services.

3. Therapy attendance expectation is to maintain no less than 70% of all therapy sessions. If you cancel or fail to schedule more than 30% of therapy sessions, then services will be suspended. If the family would like to continue to pursue ABA therapy services, then an attendance agreement must be signed prior to return.

_____ _____

(Signature) (Date)

For everyone's well-being, it is imperative to follow the illness policy. Colds/germs spread quickly, and it only takes one person to get many people sick. Your adherence to this policy is greatly appreciated.

Please insure your child is symptom-free for at least 24 hours before continuing therapy sessions. Symptoms that would require cancelation include:

- Temperature above 100.4F
- Conjunctivitis (pink eye)
- Vomiting or diarrhea with or without fever
- Impetigo, MRSA, or any other skin disease, until treatment has begun and a doctor has released your child to return to school/therapy
- Chicken pox, exclusion for six days from appearance of marks or until marks have healed
- A positive culture for Streptococcal throat infection (Strep Throat), until client has had at least 24 hours of appropriate treatment and is without a fever.
- Persistent cough
- Intense nasal discharge (not improved by the use of antihistamines)

*** IF YOUR CHILD IS TOO SICK TO GO TO SCHOOL, THEN S/HE IS TOO SICK FOR THERAPY.***

Copy of front and back of insurance card (Except for Tricare Clients):