Elevated Kids
Pediatric Developmental & Behavioral Specialists

Thank you for your inquiry regarding Applied Behavior Analysis (ABA) and Naturalistic Developmental Behavioral Intervention (NDBI) services through Elevated Kids, Developmental & Behavioral Specialists.

Elevated Kids provides sub-specialized, developmentally-appropriate and effective early intervention services utilizing evidence-based Applied Behavior Analysis (ABA) and Naturalistic Developmental Behavioral Intervention (NDBI) treatment for young children diagnosed with Autism Spectrum Disorder (ASD) or other developmental delay. Early intervention services are provided in the child's natural environment setting and individualized to meet the specific needs of each child and family. All professionals at Elevated Kids have extensive training and experience in early childhood development, developmental delays, ASD, ABA, and NDBI, to provide each child and family with the highest quality and most effective treatment available.

To begin with early intervention services, please complete and email the enclosed child intake form and questionnaire. Please include copies of any reports that have been previously completed (e.g.. evaluation report, pediatrician's report, psychometric assessment, speech and language assessment, school report, IFSP, etc). Please also include a copy of your child's health insurance card (front/back) for insurance verification. Once we have received the completed forms and documents, all information will be reviewed in its entirety for completeness. An intake officer from the team will be in contact with you to discuss next steps.

Please E-Mail all information to: ***info@elevatedkids.com***

We thank you for allowing us the privilege of entrusting your child's care to us and look forward to partnering with you to develop a plan and an approach that is specific to you and your child's needs.

Should you have any further questions, please do not hesitate to contact Elevated Kids at 267-978-4305.

Sincerely,

Amberly Caballero, MSEd, BCBA, LBS, IECMH
Executive Director/Owner
Elevated Kids, LLC

Elevated Kids
Pediatric Developmental & Behavioral Specialists

CHILD INTAKE FORM

Date: _____
Admission Status: [X] New Referral

Referral Source Information

Agency, School, Etc.: _____ Contact Name: _____
Relationship to Client: _____
Address: _____
City, State: _____ Zip: _____ Phone: _____
Diagnosis: _____ Diagnosing MD: _____
Reason for Referral:

Services Required

[X] Applied Behavior Analysis (ABA)/Naturalistic Developmental Behavioral Intervention (NDBI) Services
Current Therapy (Where/When): _____
Current Placement: _____
Prior Therapy (Where/When): _____

Client Information

Client's Name: _____ DOB: _____
Address: _____
SS#: _____ MA#: _____ School: _____
Parent/Guardian Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail: _____
Parent/Guardian Name (2): _____ Phone: _____
Emergency Contact Name: _____ Relationship: _____ Phone: _____
Family Physician Name: _____ Phone: _____

Private Insurance Information

Private Pay: ☐

Insurance Carrier: _____
Address: _____
Subscriber's Name: _____ DOB: _____
Address: _____
ID#: _____ Group #: _____ SS#: _____
Employer's Name: _____ Phone: _____
Address: _____
HR-Benefits Contact Name: _____
Self-Insured Group: ☐YES ☐NO
Policy Effective Date: _____ Renewal Date: _____

Elevated Kids
Pediatric Developmental & Behavioral Specialists

Intake Questionnaire

Parent: _____ **Date:** _____

Child: _____ **DOB:** _____

1. What are you hoping to gain from services? What are your main goals for your child?

2. Has your child had an evaluation? If yes, did your child receive a diagnosis?

3. Does your child currently have any of the following challenges?

Please check all that apply:

- ☐ Prefers to play alone
- ☐ Repeats back what you say, or says the same thing over and over
- ☐ Difficulty making eye contact
- ☐ Difficulty understanding what you say or following directions
- ☐ Difficulty sharing or taking turns
- ☐ Slow to learn gestures, words, or combine words into sentences
- ☐ Limited interest in toys or other play materials
- ☐ Difficulty communicatingfor a variety of purposes
- ☐ Plays in unusual ways or in the same way over and over
- ☐ Difficulty imitating what you do or say

4. How does your child communicate with you?

Elevated Kids
Pediatric Developmental & Behavioral Specialists

5. Do you have any concerns about your child's behavior, such as temper tantrums, feeding issues, or sleeping issues? If so, how much do these problems affect your family's day-to-day functioning?

6. Has your child received intervention services, previously or currently? If yes, what treatment methods have been used in these programs, and what has been your experience with them?

7. What are your expectations of your role in your child's therapy sessions?

8. Who spends the most time with your child? Is there someone else who should participate?

9. What languages are spoken in the home? What is the primary language?

10. Are there any issues that will make it hard to attend sessions? If yes, what are they?

Elevated Kids
Pediatric Developmental & Behavioral Specialists

Getting Started Questionnaire

1. Who does your child spend time with during the week?

2. Does your child have siblings? If yes, please list them and give their ages.

3. Please describe your main goals for your child.

4. Please describe goals you have for yourself.

5. Please list some activities your child enjoys.

6. Is your child currently receiving any other services (e.g., early intervention, occupational therapy, speech–language therapy, behavior therapy)? If yes, please describe the service (e.g., treatment method), the service provider, and your experience with the program.

7. Please list any other information that may be helpful and attach any previous evaluations or treatment plans.

Elevated Kids
Pediatric Developmental & Behavioral Specialists

8. Does your child have an Autism Spectrum Disorder (ASD) Diagnosis: ___ No ___ Yes ___ N/A

Date Established: _____

Does your child have any other developmental diagnosis: _____

9. Developmental Evaluation Completed: ___ No ___ Yes ___ N/A

10. OT Evaluation Completed: ___ No ___ Yes ___ N/A

11. Speech & Language Evaluation Completed: ___ No ___ Yes ___ N/A

Medical History:

12. List Any Medical Issues:

13. List Medications (include frequency and dosage):

14. Date of Last Physical Exam: _____

15. Date of Last Dental Exam: _____

16. Date of Last Hearing Exam: _____

17. Date of Last Vision Exam: _____

Elevated Kids

Pediatric Developmental & Behavioral Specialists

Hours of Availability

Please mark the times (X) you and your child are available for services:

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
12:00 pm					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					

Additional Comments

_____

_____

_____

_____

_____

Elevated Kids
Pediatric Developmental & Behavioral Specialists

Evaluations/Assessment Reports

Please attach a copy of your insurance card (front and back)

☐Check that a copy of each side is included with this packet

Please attach a copy of your child's reports (please include all that apply):

☐ Diagnostic Evaluation Report

☐ IEP/IFSP/504 Plan

☐ Functional Behavior Assessment (FBA) /Behavior Intervention Plan (BIP)

☐ Prescription for ABA

☐ Mental health directives (If applicable)

☐ Powers of attorney

☐ Discharge summaries or evaluations from any ABA services within the last 5 years

☐ Speech/Occupational Therapy/Early Intervention Evaluation Report

☐ Other: _____

Educational History

Please list the schools attended from most recent.

1. Is your child currently enrolled in daycare, pre-school, or elementary school? ___ No ___ Yes ___ N/A
   School Name: _____School District: _____
   Program or Grade level: _____

2. Is your child receiving or has your child received special services or accommodations at school? ____ No ____ Yes If yes, please explain what type: (e.g. IEP, IFSP, 504 Plan) _____
   _____
   _____

Elevated Kids

Pediatric Developmental & Behavioral Specialists

Client Communication Agreement

Individual providers and clients may decide to use email to facilitate communication. Some providers at Elevated Kids may communicate via email, but this agreement does not obligate all Elevated Kids providers to communicate via email. Email may be one of many forms of communication with Elevated Kids.

Risk of using email

I agree to use email to communicate to Elevated Kids providers and staff about my/the child's personal health care. I understand that Elevated Kids providers and staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may affect the privacy of my personal health care information when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Email may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.
- Email delivery is not guaranteed.

Conditions for the use of email

I agree that I must not use email for medical emergencies or to send time sensitive information to my/the child's providers. I understand and agree that it is my responsibility to follow up with Elevated Kids providers or staff, if I have not received a response to my email within a reasonable time period.

I agree that the content of my email messages should state my question or concern briefly and clearly and include (1) the subject of the message in the subject line, and (2) clear identification including child's name, parent's name, and telephone number in the body of the message. I agree it is my responsibility to inform Elevated Kids of any changes to my email address. I agree that, if I want to withdraw my consent to use email communications about my child's healthcare, it is my responsibility to inform my child's providers or staff member only by email or written communication.

Understanding the use of email

I give permission to Elevated Kids providers and staff to send me email messages that include my child's personal health care information and understand that my email messages may be included in my child's medical record. I have read and understand the risks of using email as stated above and agree that email messages may include protected health information about me/my child, whenever necessary.

Email address: _____

Print child's name_____

_____

Signature (Parent/Guardian if under 18) **Date**

_____

Printed Name **Relationship to child**

Elevated Kids
Pediatric Developmental & Behavioral Specialists

Confidentiality

The ABA/NDBI approach to intervention will utilize developmental sequences to guide intervention goals and strategies and the principles of Applied Behavior Analysis (ABA) to evaluate, analyze, and teach new skills. An individualized treatment plan will be created to meet the needs of each child and family. Parent coaching goals will also be developed that are meaningful to the parent and address parent need and support. A collaborative parent partnership is important as it leads to positive long-term outcomes and individual family success. ABA/NDBI intervention is a clinical process that involves a professional arrangement, and may include developmental skills assessment, parent interviews and questionnaires, direct observations, Functional Behavioral Assessment (FBA), behavior intervention plan, and direct treatment. ABA/NDBI intervention is regulated by laws, ethics, your rights as a client, and by standard business practices. Before ABA/NDBI intervention can begin, your agreement to the business practices described herein is required.

Treatment Termination

If at any time during the course of treatment it is determined services cannot continue, you will be provided an explanation for the justification for this decision. Ideally, services end when treatment plan goals have been achieved. Additional conditions of termination can include:

- You have the right to stop treatment at any time. If you make this choice, referrals to other therapists may be provided (if available).
- Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefit. If it is determined that the services are not proving to be clinically beneficial, ethical conduct requires a coordination of care discussion around treatment options and planning.
- Other situations that warrant termination may include: drug abuse, disclosing illegal intentions or actions, inappropriate behavior during services, or failure to meet treatment expectations (i.e., numerous cancellation of sessions)

HIPAA

I hereby give my consent for Elevated Kids to use and disclose Protected Health Information (PHI) about my child to carry out treatment, payment, and health care operations.

I understand and recognize my right to request review and/or obtain copies of any medical records relating to services provided to my child that are collected, maintained, or used by Elevated Kids such as progress reports, assessments, and/or treatment plans. Any such request must be made in writing to Elevated Kids. All requests shall be reviewed for appropriateness, and if required, a "Voluntary Authorization to Release Information" may be requested.

Financial Responsibility

I assume personal responsibility for the payment of all fees, deductibles, co-pays/co-insurance, and agree to the rules and regulations of Elevated Kids. Payment for services will be due within 14 days of the statement date billed to insurance and/ or receipt for services rendered for self-pay clients.

My signature below verifies that I have read all the information contained in this Informed Consent and that I asked questions about anything I have not understood up to this point.

By signing, I freely acknowledge my willingness for my child to undergo ABA/NDBI treatment with Elevated Kids:

_____ _____

Signature of Parent/Guardian Date Signed

_____

Printed Name of Parent/Guardian