CLIENT INTAKE

Client/Parent Information	
Client Name:	Parent(s)/Caregiver(s) Names:
DOB:	Address:
SSN:	Email Address:
Diagnosis:	Cell Phone:
Referred by:	Emergency Contact Name/Phone:
Insurance #1 Information	
Insurance #1	Relation to Patient:
Insured:	Insured DOB:
Insured SSN:	Group Name:
Insured Address	Group Number:
Policy #:	***Please provide card to office***
Insurance #2 Information	
Insurance #2	Relation to Patient:
Insured:	Insured DOB:
Insured SSN:	Group Name:
Insured Address	Group Number:
Policy #:	***Please provide card to office***

Primary Care Physician	
Name:	Phone:
Fax:	Address:

Medical History

- ☐ Unusual circumstances during pregnancy or birth
- ☐ Medical problems after birth
- ☐ Any physical problems
- ☐ Vision difficulties
- ☐ Hearing loss
- ☐ Ear infections
- ☐ Tubes
- ☐ Allergies ____
- ☐ Seizures
- ☐ Surgery
- ☐ Feeding Concerns
- ☐ Medication ____

Copy of prescription provided for services to office? Yes No

Explain any checked boxes above:

____

____

____

Feeding Issues

Current Diet: ____

- ☐ Drinks from cup
- ☐ Finger foods
- ☐ Uses utensils
- ☐ Uses straw
- ☐ Eats a modified diet: ____
- ☐ Exhibits coughing/drooling
- ☐ Exhibits sensitivity to textured foods
- ☐ Nutrition concerns: ____
- ☐ Past feeding evaluation results: ____
- ☐ Food allergies: ____

Behavioral Language Interview

How easy is it to work with the child?

How does the child let his needs and wants be known (speech, sign, PECS, device, single words, sentences, etc)?

Does the child copy actions?

Does the child spontaneously say sounds and words? Is speech intelligible to familiar listeners?

Will the child match objects and pictures?

Does the child follow 1 and 2 step directions?

How many items in the environment can the child label through speech or sign?

Can the child receptively identify objects by name, feature, function, or category?

Can the child fill in words to familiar songs?

Can the child answer basic questions?

Can the child ask basic questions?

Does the child engage in age appropriate interactions with both adults and same age peers?

Family History of Mental Health/Substance Abuse/Medical:

Legal History or Cultural/Religious Values to Note:

Motor and Writing Milestones	
Walks Yes/No Toe walks? Yes/No	Manipulates small objects Yes/No
Runs Yes/No	Scribbles Yes/No
Jumps Yes/No	Copies letters or name Yes/No
Climbs Stairs Yes/No	Writes name Yes/No
Throws and catches Yes/No	Cuts lines and shapes Yes/No
Kicks ball Yes/No	Fastens clothing and ties shoes Yes/No ____
Rides bike Yes/No	Manipulates utensils for self feeding Yes/No
Attention	
Does your child get distracted? ____ Very Easily ____ Easily ____ Occasionally ____ Not at all	**Does your child have problems completing a task?** ___Yes ___No ___
Is your child overactive? ___Yes ___No ___N/A	**Is your child impulsive?** ___Yes ___No ___N/A
Does your child have trouble following verbal directions? ___Yes ___No ___N/A	**Does your child have difficulty understanding or remembering what someone says?** ___Yes ___No ___N/A
Social Skills	
Are interests age appropriate? List a few.	Does your child fixate on certain interests or topics?
Does child play alone or with others?	Does difficulty with social skills cause anxiety?
Does your child make appropriate eye contact?	Other concerns?
Sensory Issues (Check all that apply)	
_____ Rocking _____ Seeks pressure _____ Puts non-food items in mouth _____ Sensitivity to clothing _____ Sensitivity to temperature	_____ Seeks visual input such as objects that spin _____ Seeks movement activities (swinging, car rides) _____ Sensitivity to touch _____ Sensitivity to light _____ Sensitivity to noise

_____ Flapping or other self-stimulating movement   _____ Sensory issues functionally impact my child

Behavioral Concerns

Describe your child's problem behaviors.
____
____\

What happens before and after the behaviors you describe?
____
____

Does your child listen to some adults more than others? Why?
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____

What happens when you place a demand on your child?
____
____

Does your child seek attention through maladaptive behaviors?
____
____

Does your child's communication skills impact his or her behavior and how?
____
____

Does your child display obsessive compulsive tendencies?
____
____

Explain your child's ability to independently attend to and complete academic or daily living activities:
____
____

Does your child have difficulty with bedtime routines?
____
____

Is your child Potty Trained? Yes/No Bladder   Yes/No Bowel

Does your child have behavior while riding in a vehicle?
____
____

Education and Leisure Information

School: _________________________   Working at ______ grade level   Teacher: _____________________
Favorite subject: __________________   Least favorite subject: _____________________

Favorite toys and
activities:____
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What should we know that was not included on this form?
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Questions for office or therapist:

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I certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in the above information within 30 days.

Signature of guardian: ____________________________________Date: _________________________

Permission to Evaluate and Provide Therapy

Please complete the below portion of this form to grant permission for Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC to evaluate your child and provide services as needed.

I, ______________________ am seeking ABA services and authorize Piece by Piece/Indiana Autism Center to evaluate and provide the recommended services to _______________________.
Child's Name

Frequency and duration of service is contingent upon the results of the evaluation and the impending recommendation of the responsible therapist or professional Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC has promised no specific outcomes as to the services provided at this facility.

___________________________________	________________________________
Signature of parent/guardian	Printed name of parent/guardian

Financial Responsibility

I authorize Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC to bill my insurance and receive direct payment from my primary insurance as well as my secondary insurance companies so that Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC will be paid for the therapy services provided. Furthermore, I understand that I am financially responsible for any fees not paid or covered by my insurance providers. I also acknowledge that I am responsible for co-pays, co-insurance and deductibles which are included as part of my insurance contracts.

By signing this form, I understand and agree that regardless of insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

________________________ ________________________
Patient Name Date

X________________________ ________________________
Signature Relationship

X________________________ ________________________
Witness Date

Attendance & Participation Policy

Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC believes consistent treatment is imperative to the success and progress of our client's development. Families and therapists should have a trusting and established relationship and we believe that having an explicit attendance and participation policy clearly outlines the expectations for each party. Having an explicit policy and set expectations will help facilitate communication and teamwork as therapists and families work together to overcome illnesses, traffic, and other obstacles that life presents.

In the case of illness or any other reason for a cancellation, please call the office by 7:00AM on the day of your appointment. Any calls received after 7:00AM on the day of the appointment, are subject to a cancellation fee of $30.00 for the missed session.

Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC will also call the parent by 7:00AM the day of the session if a therapist has to unexpectedly cancel.

If a child misses more than 2 sessions in a row without following the above procedures, Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC may contact the parent about further participation in therapy with Piece by Piece/Indiana Autism Services. A signature by the parent or legal guardian and the provider will acknowledge an understanding of the Attendance & Participation Policy.

Child's Name: ___________________ Date: __________

Parent Signature: _________________ Date: __________

Provider Signature: _________________ Date: __________

Parent/Guardian Release for Administration of Medicine

Please complete the following required information for your child if you request medication to be administered at Piece by Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC.

Name: ________________________

Medication Allergies: ________________________

Medication Name:____________________________
Strength:__________
Dose: ____________
Time/s To Be Given: ____________
Date/s To Be Given: ____________

I hereby give permission for Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC staff to oversee administration of the medication specified above for my child.

Parent Signature: __________________________ **Date**: ___________

HIPAA Authorization

Child's name: ___________________ Date of Birth:____________
Address: ____

I hereby authorize use or disclosure of protected health information about my child as described below:

Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC and its employees are authorized to use or disclose health information that is pertinent or required for therapy purposes. Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC may disclose health information considered pertinent to services to a patient's insurance company, physician, teacher, social worker, and other involved professionals. In addition, I give permission for the individuals listed below to observe my child's therapy sessions and to sign any required documentation related to my child's treatment. I may revoke this authorization by notifying Piece by Piece/Indiana Autism Services in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization expires when a patient is discharged by Piece by Piece/Indiana Autism Services or receives a written desire to revoke it.

Name/Contact Information of involved professionals:

____________________ _________________________ _________________________

____________________ _________________________ _________________________

Physicians:

Name:______________________ Name:_____________________
Address:____________________ Address:___________________
___________________________ __________________________
___________________________ __________________________
Phone:_____________________ Phone:_____________________
Fax:________________________ Fax:_______________________

__________________________ ___________________
Parent/Guardian Signature Date of Signature

Notice of Privacy Practices

This notice describes how health information about you or your child may be used and disclosed to coordinate health care and how you can get access to this information.
Please review it carefully.
The privacy of you or your child's health information is important to us.

Our Legal Duty
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION
This Notice allows us to use health information about you or your minor child if you are a parent or guardian, as necessary, for coordinating treatment, payment, and healthcare operations. We will limit the release of information necessary to assist in the specific need. For example, Treatment schedules will be posted in our office to assist in providing treatment. We may disclose health information to a physician or other healthcare provider treating you (or your child).

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluations practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Marketing Health-Related Services: We will not use your (or your child's) health information for marketing communications without your written authorization.

Abuse or Neglect: We may disclose your (or your child's) health information to appropriate authorities if we reasonably believe that you (or your child) are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your information to the extent necessary to avert a serious threat to your (or your child's) health or safety or the health and safety of others.

Contact Modes: We will use voicemail or answering machine messages, post cards, e-mails or letters if we cannot reach you personally. If we cannot speak to you directly, we will limit the information divulged as much as possible, except in matters of medical necessity.

PATIENT RIGHTS:
Access: You have the right to look at or get copies of your (or your child's) health information, with limited exceptions. We will use the format you request unless we cannot reasonably do so. (You must make a request in writing to obtain access to your (or your child's) health information)

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your (or your child's) health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with your about your (or your child's) health information by alternative means or alternative locations. **(You must make your request in writing)** Your request must specify alternative means or location, and provide satisfactory explanation of how payments will be handled under alternative means or location which you request.

Amendment: You have the right to request that we amend your health information. (**Your request must be in writing and it must explain why the information should be amended)** We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS
If you would like more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may make a formal complaint to us, or submit a written complaint to the US Department of Health Services. We will provide you with the address to file your complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________________, have received a copy of Piece by Piece Autism Center, LLC/Piece by Piece ABA Therapy Center, LLC/Indiana Autism Services, LLC Notice of Privacy Practices.

_________________________________ _________________________

Signature Date