Client Intake Form

Rise With ABA
25510 Kearsley Dr. Katy, TX 77494
(979) 627 - 8138

Dear Parents/Guardians,

Welcome to Rise With ABA! We are grateful that you are interested in our program and look forward to meeting you and your family. We are an in home/clinic based ABA (Applied Behavior Analysis) program that provides one-on-one therapy for children diagnosed with Autism, as well as other Autism Spectrum Disorders. We provide quality, caring service to each child that is enrolled. Each staff member is highly trained and dedicated to meet the needs of the families and children they serve.

The first step in enrolling in our program is completing the necessary paperwork for your child. Please thoroughly fill out each page of the client application packet that is provided below. If you have any questions along the way, please contact me during our scheduled business hours.

Thanks again for your interest in our program!

Sincerely,
Eunhee (Amy) Lee
Owner
Rise With ABA
(979) 627- 8138
amy.lee@risewithaba.com

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Client Start Date: _____
(Office to complete)

Today's Date: _____

Client Legal Name:

_____
Middle Initial Last Name First Name

Name Client goes by: _____ Date of Birth: _____ Gender: M / F

Home Address: _____

City: _____ State: _____ Zip: _____

Family Information

Client lives with: _____

Parent/Guardian 1
Name: _____Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Employed by: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

Parent/Guardian 2
Name: _____Relationship: _____

Address: (if different) _____ City: _____ State: _____ Zip: _____

Home Phone: (if different) _____ Cell Phone: _____

E-mail Address: _____

Employed by: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

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Insurance Information

I understand that in some medical situations, the staff will need to contact local emergency resources before the parent/guardian, child's physician and or other adult acting on the parent/guardian's behalf.

Name of Primary Insurance: (Private or MA) _____

Member Number/MA number: _____ Group Number: _____

Subscriber Name: _____

Name of Secondary Insurance: (If Primary insurance is private) _____

Member Number/MA number: _____ Group Number: _____

Subscriber Name: _____

Assignment of Insurance Benefits

I understand the confidentially of my records as protected by law. Information about me/my child cannot be released without my consent. I understand I may revoke this consent at any time, and it will automatically expire without my revocation after one (1) year from the date of signature.
I hereby give authorization for Rise With ABA to contact and inform my primary and secondary (if applicable) insurance companies of all medical information included in treatment plans relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressively agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize the Insurance Companies named above to pay and hereby assign directly to Rise With ABA all benefits, if any, otherwise payable to me for his/her services. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received and paid to Rise With ABA will be credited to my account, in accordance with the above assignment.

_____ _____

(Authorized signature of Subscriber) (Date)

Medical Information

Hospital/Clinic Preference: _____

Client's Primary Doctor: _____ Doctor Phone Number: _____

Allergies: _____

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List any medication routinely taken at home: _____

_____

List any medical restrictions to client's activities: _____

_____

List any special dietary needs: _____

_____

Additional Service Providers

Social Worker: _____ Phone Number: _____

Interpreter: _____ Phone Number: _____

School: _____ Grade: _____

Teacher's Name: _____ Phone Number: _____

Other Providers (if applicable)

Name: _____ Type of service: _____ Phone number: _____

Name: _____ Type of service: _____ Phone number: _____

Strengths

Please list all of your child strengths such as drawing, writing, computer, etc.

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Main Concerns

Please list any concerns the child may have at home or in the community. This may include, but 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 the child's progress.

Possible Reinforcers

Please list all or any preferences that your child has shown and put * next to the ones that are highly preferred in each category. Be as SPECIFIC as possible!!

FOOD: (snacks, candies, chocolate – please be specific; kind or brand names)

TOYS: (games, stuff animals, etc.)

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PHYSICAL CONTACT: (tickles, hugs, kisses, clapping, back rubs, etc.)

ACTIVITIES: (reading books, listening to music, etc.)

OTHER: (any special preferences not mentioned)

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Release of Consent

Client name:_____

A separate Consent for Exchange of Information form must be completed for each individual or agency you wish for Rise With ABA to communicate with.

- I understand that my records are protected by data practice laws and cannot be released without my consent unless otherwise allowed by law.
- I understand that only the information and records indicated below will be released or obtained.
- I understand that this consent does not authorize the recipient of the information or records to re-disclose the information or records to any other person or facility unless authorized by law.
- I understand that the information will only be used for the purposes indicated below.
- I understand that I may withdraw or modify this consent at any time but, that the revocation or modification will not affect any release of information that previously occurred.
- I understand that this consent with expire and no longer be valid **one year** from the date it was signed.
- I understand that the observation and/or assessment can take place in either setting.

I Authorize:

Rise With ABA
25510 Kearsley Dr, Katy, TX 77450
Name of Staff: _____

To obtain records from or release records to:

Name of Agency: _____
Name of Staff: _____

Type of information released:

___Assessments or evaluations
___Behavior reports
___All
___Educational records
___Medical records
___Other: _____

Information may be shared in person or by mail. I also give permission to share information using the following methods:

___Phone
___Fax
___All
___Email
___Other: _____

_____ _____

Parent or Guardian or Authorized Representatives Signature Date

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Rise With ABA Consent Form

I, _____, as parent/legal guardian of _____, give permission for my child/ward, (hereinafter "Participant") to participate in Rise With ABA for Autism Early Childhood Program. I have received an enrollment application package and have read, understood and completed all the necessary forms required prior to enrollment. I agree with the current personal development goals established for Participant, and I am aware that I will be required to attend periodic meetings for review and revision of Participant's individual program. I also understand that I may withdraw Participant at any time. I understand that Rise With ABA for Autism reserves the right to terminate the enrollment of Participant for failure to adhere to program standards.

I also give permission for Rise With ABA to use any necessary information and data collected on Participant to be reviewed and used in presentations at any professional meetings and conferences. I understand that Participant's name and identity will be kept confidential and will not be disclosed without prior written notification. I also understand that this will serve to further the advances in the field of autism.

I hereby agree to hold harmless and release from any and all liability, Rise With ABA, its directors, officers, employees, agents, affiliates, sponsors, and promoters, as well as, their respective directors, officers, employees, and agents (hereinafter collectively known as ,'Rise With ABA'), for any injury or illness to the Participant, arising out of or in connection with his/her participation in Rise With ABA. Also, to the fullest extent allowed by law, I hereby waive and discharge my and the Participant's rights, including those of our heirs and assigns, to any and all claims of damages for injury or illness to the Participant Rise With ABA. I agree that health insurance coverage for the Participant is my sole responsibility.

Parent/Guardian comments:
_____
_____
_____
_____

_____ _____
Parent or Legal Guardian Name (Please Print) Date

_____ _____
Parent or Legal Guardian Signature Date

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Client Notification of Privacy Rights

Health Insurance Portability and Accountability Act (HIPAA)

Recent federal law, the Health Insurance Portability and Accountability Act (HIPAA), has created new client protections surrounding the use of protected health information. Commonly referred to as the " medical records privacy law," HIPAA provides client protections related to electronic transmission of data, the keeping and use of client records, and the storage and access to health care records. HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Client Notification of Privacy Rights is designed to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can do to protect the privacy of your mental health records.

HIPAA requires that we secure your signature indicating you have received or been offered the Client Notification of Privacy Rights document.

I have accepted a copy of the Client Notification of Privacy Rights document. _____

I have been offered a copy of the document and do not wish to have a copy at this time. _____

(I understand I have the right to review the document before signing this acknowledgement form.)

_____ _____

Client's Name (print) Client or Legal Guardian Signature

_____ _____

Client Date of Birth Date Signed

Please sign and return this page to the office. You may retain the notification document for you records.

HIPAA Privacy Rights Notification 06-

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FACE Sheet

Please complete the form below by providing as much information as possible regarding your child. This information will be given to medical personnel in case of an emergency.

Name	
Birth Date	
Parent/Guardian	
Home Address	
Home Phone Number	
Cell Phone Number	
Work Phone Number	
Primary Insurance	Name:
	Member Number:
	Group Number:
Secondary Insurance	Name:
	Member Number:
	Group Number:
Hospital/Clinic Preference	
Primary Doctor	
Allergies	
Other Information	
Rise With ABA	25510 Kearsley Dr Katy, TX, 77494 (979) 627- 8138

_____ _____

Parent or Legal Guardian Signature Date

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Additional Information

Thank you for completing the client registration packet. In addition to submitting the application packet, please include the following items when applying for enrollment:

- Copy of your child's insurance card(s)
- Medical documentation pertaining to the diagnosis of autism
- Reports from other service providers (if applicable)
    - Speech therapy, school services, occupational therapy, etc.

Please contact the center if you have any questions when completing the application packet, or regarding the intake process.

Thanks again,

Eunhee (Amy) Lee
Owner
Rise With ABA
(979) 627 - 8138
amy.lee@risewithaba.com