Milton Speech Pathology Therapy & Learning Center of GA

ABA Intake Questionnaire

Identifying Information:

Patient Name:_____ Date of Birth: _____

Parent/Guardian Names: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail:_____

Phone 1: _____ Phone 2: _____

Insurance Information

☐ Check this box if you plan to pay privately for services.

Insurance Company: _____ ID Number: _____

Subscriber Name: _____ Group Number: _____

Medical Information

Current Diagnoses: _____

Educational Information

Name of School: _____

Classroom Type: _____

Behavioral Provider (if any): _____

Speech Provider (if any): _____

OT Provider (if any): _____

Other Therapy Provider (if any): _____

Milton Speech Pathology Therapy & Learning Center of GA

Please describe your child's strengths and interests.

_____

_____

Please describe your child's current challenges with respect to communication and social skills.

_____

_____

Please describe your child's current challenges with respect to communication and social skills.

_____

_____

Please describe your child's current challenges with respect to behavior.

_____

_____

Please describe your child's current challenges with respect to functional/daily living skills.

_____

_____

Please describe your goals for your child, specifically with respect to ABA services.

_____

_____

What is your ideal schedule for behavioral services? What days of the week and hours would you like to have a behavioral technician working with your child?

_____

_____

Credit Card Payment Authorization Form

Sign and complete this form to authorize Therapy & Learning Center of GA to make a debit to your credit card listed below. We require that patients keep a credit card on file for payment. This is because we do not have front office staff to process your card each day.

By signing this form, you give us permission to debit tour account for services rendered.

Please complete the information below.

I, _____, authorize Therapy & Learning Center of GA to charge my credit card account for the amount indicated on my bill on or after the date of my child's service. If I am using insurance, the credit card will be processed after the insurance company provides and EOB outlining the negotiated rate for services. I will be notified of this rate before my credit card is processed. This payment is for Speech and Language Therapy, Occupational Therapy, or Academic Tutoring. Credit cards are processed at the end of the week.

Billing Address: _____ Phone #: _____

City, State, Zip: _____ Email: _____

Account Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name: _____

Card/Account #: _____

Expiration Date: _____ CVC: _____

Signature Date

_____ _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount explained to me. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated int his form and for the amount explained to me.

Milton Speech Pathology Therapy & Learning Center of GA

Policies and Procedures

Appointments:

Please arrive at your appointment 5 minutes early. In the event that you arrive late for your appointment, the appointment may be shortened due time constraints. If you must cancel an appointment, please call immediately. We understand that life happens. We have a 24 hour cancellation policy. ***Therefore, please cancel appointments scheduled for the following day before 10 pm the evening prior via email, phone or text. The full service fee will be charged for no shows and last minute cancellations***. In the case of a **child's illness**, cancellations will be accepted **before 8 am**. ***This includes school visits. Please do not count on your child's school to notify MSP.***

Patients are required to attend 75% of speech sessions. *In the event that attendance drops to 50% over 2 months, we reserve the right to forfeit your child's space.* ***After 2 no show appointments (no call, no email, no text)*** *for any reason, we reserve the right to forfeit your child's space.*
This does not apply to social skills groups. Social skills group students will be offered one make up session free of charge after the semester to cover the cost of all missed sessions. One hour social skills group lessons allow for 50 minutes in group and 10 minutes group/parent education.

Fees:

A schedule of fees can be obtained from our website. **You are required to inform us about changes in insurance. In the event that you fail to inform us and the insurance denies the claim, you will be responsible for the full payment.** Enrollment in social skills groups requires a *non-refundable payment* for the first 50% of classes upon enrollment. For example, when you enroll for an 8 class session, the fee for 4 sessions will be due 1 week prior to the start of group. The remainder is due after the 3rd class. We will charge your card after the 3rd class automatically. We will hold 1 make-up class free of charge after the end of the session for all students who have missed classes**. Verification of insurance is not a guarantee of payment. In the event that your insurance does not pay for service, you will be responsible for the fee. It is your responsibility to let us know if your insurance changes.** If you do not let us know and we do not have authorization for treatment from the new company, they may not pay and you will receive a bill.

Schools: There is a $10 travel fee when therapists see patients at school.

Times: As per the consent form, if you elect to a service time that is beyond what is covered in your insurance, you are voluntarily agreeing to pay for the extra time as per your insurance's adjusted rate.

CAMP: Should you need to cancel camp 4 weeks prior, 100% of your payment will be refunded. Should you need to cancel camp 2-3 weeks prior 50% of your payment will be refunded. Should you need to cancel camp less than 1 week prior, 25% of your payment will be refunded.

_____ _____

Print Client's Name Relationship to Client

_____ _____

Signature of Parent or Legal Guardian Date