INFINITE ABILITIES LLC
GOING BEYOND THE SPECTRUM

Patient Information Questionnaire

Last Name:	First:	Middle Initial:
Patient SS#:	Patient D.O.B. :	Sex: □Male □ Female
Address:		Apt#:
City:	State:	Zip Code:
Home #:	Cell #:	Email:
Is it ok to leave a voice message on your home or cell? ☐ Yes ☐ No		
Diagnosis:		
Diagnosis Code (if known):		

INSURANCE INFORMATION*: (please make sure to write in all of the information below)*
If your child has Medicaid, we will need the Medicaid ID number and the GOLD CARD number.

Name of Insurance:
Medicaid ID:
Gold Card #:

Secondary Insurance – Or Primary if no Medicaid coverage

Name of Insurance:
Member I.D. #:
Group #:
Patient's SS# (Only if policy holder is different than patient):

Parent/Guardian Information

Name:	Relationship:
Address :	Phone #:

Name:	Relationship:
Address :	Phone #:

Emergency Contact

Name:	Relationship:
Home #:	Work #:
Name:	Relationship:
Home #:	Work #:
Name:	Relationship:
Home #:	Work #:

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**** PLEASE READ****

Infinite Abilities and our staff CANNOT move forward in obtaining authorization for your child's ABA services unless this form and the following form are filled in <u>completely</u>. After this form and the following form (Release of Information) is completed, please send to our staff at the contact information listed below.

On the Release of Information form please make sure to write in the Doctor's Name, and contact information so we can contact your child's Doctor to obtain proof of diagnosis.

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You may reach Infinite Abilities Office at 229-251-7930
You may reach Infinite Abilities Owner/Director, Ashley R. Michaels, MA, BCBA, LBA , at 229-251-7930 or at ashleymichaels@iabilitiesaba.com

RELEASE OF INFORMATION

INFINITE ABILITIES LLC
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Patient Information Questionnaire

Infinite Abilities LLC

Client Name:_____ **DOB**: _____

This authorizes the release or ability to obtain protected health information concerning the above named client. Health information may relate to my past, present or future physical or mental health condition, and the provision of my health care, or payment for my health care services. This information may be disclosed to or obtained from the following:

Agency Name/Contact Person: _____

OR

Doctor's Name and Practice: _____

Mailing Address: _____

City, State, Zip: _____

Delivery Method: □ Mail □ Phone □ Fax □Email

I authorize □ ALL Health information to be disclosed OR only the following information is/are authorized for disclosure (check all to be released).

□ Individual Education Plan (IEP)	□ Speech/Language Eval.	□ Client Information Sheet
□ Psych Educ. Assessment	□ Hearing Screening	□ Individualized Treatment Plan
□ Report Cards/Transcripts	□ Medical History and Physical	□ Treatment Plan Reviews
□ Behavioral Report	□ Immunization Record	□ Psychosocial Evaluation
□ Special Report	□ Neurology Report	□ Behavioral Program
□ Psychological Evaluation	□ Psychiatric Evaluation	□ Discharge Summary
□ Medication Management Visits	□ Progress Notes	□ Progress Summary

Expiration: This authorization expires or (exp. Date)

Purpose of the Release: □ At the request of the Individual □ Assessment □ Treatment

Coordination

□ Disability Determination □ Other – Please specify □ To obtain information for Brief Behavioral Health Status Exam

Other Information:

- I understand that Infinite Abilities cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information.
- I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Infinite Abilities.
- I understand that I may revoke this Authorization in writing at any time, however, l cannot revoke authorization for action that has already been taken. I further understand that I must provide any notice of revocation in writing to the Business Office at the address listed above.

A copy of this release shall be valid as the original.
THIS CONSENT EXPIRES I YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.

_____ _____

Electronic or Hand Written Legal Guardian Signature **Date:**