



www.abatherapycenters.com

abatherapycenters@gmail.com

Virtual Social Skills Group

Zoom with ABA Therapy

Social skills groups provide a structured setting for minor children (18 and under) to learn and practice social skills in a safe environment.

Our social skills groups aim to improve the skills of socially struggling kids. Examples of just some areas focused on in the social skills groups include:

- Following group rules
- Listening to others
- Respecting boundaries/personal space
- Showing sportsmanship
- Learning to calm oneself/controlling frustration
- Learning to disagree appropriately
- Dealing with bullies/conflict resolution
- Maintaining friendships
- Saying goodbye
- Initiating conversation/Sustaining conversation
- Considering the interests of one's conversation partner
- Taking the perspective of others
- Sharing/turn-taking

Groups ages 5-12 meet every Wednesday from 10:00am – 11:00am
And group ages 13-19 meet every Wednesday from 2:00pm -3:00pm

The fee to participate in the social skills group is \$40/session.

The groups typically run for 12 sessions, one session per week, and we ask that participants commit to completing an entire 12-week cycle.

Children can continue with another 12-week cycle after completing the first one.

We are able to bill insurance to cover the cost of the group in some circumstances.

To Enroll, complete this registration form and send it to
abatherapycenters@gmail.com

SOCIAL SKILLS GROUP REGISTRATION

PARTICIPANT INFORMATION

First Name		Last Name	
Age:	Date of Birth	Sex: M <input type="checkbox"/>	or F <input type="checkbox"/>
Phone ()		Email	
Address			
City		State	Zip County
Current Diagnosis:		Receiving ABA therapy <input type="checkbox"/> YES or <input type="checkbox"/> NO	
<i>Other medical conditions we should be aware of?</i>			
Email address:			

EMERGENCY CONTACT

Name	Phone ()
Name	Cell ()

PROGRAM REGISTRATION

CHECK THE BOX THAT INDICATES THE PROGRAM YOU ARE REGISTERING FOR

<input type="checkbox"/> SOCIAL SKILLS GROUP	<input type="checkbox"/> 5 - 8 YEARS <input type="checkbox"/> 9 - 12 YEARS <input type="checkbox"/> 13 - 16 YEARS <input type="checkbox"/> 17 - 19 YEARS	\$40.00 per session
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Email Completed:

- Participant Registration Form
- Consent for Treatment (Signature Required)
- Social Skill Profile Form - 4 PAGES (FOR ALL PARTICIPANTS)
- Program Fee- credit card information form and insurance information form

Email To: abatherapycenters@gmail.com

**REGISTRATION FORM, WAIVER, PARTICIPANT INFORMATION SHEET & FULL PAYMENT
MUST BE RECEIVED 7 DAYS BEFORE PROGRAM START DATE. NO EXCEPTIONS.**

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Received by:	Member ID #	PAYMENT: <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE RECEIVED
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CONSENT FOR SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

Social Skills groups can be a powerful and valuable venue for growth. It is the desire of your group facilitator(s) that the child reap all the benefits group has to offer. To help this occur, groups are structured to include the following elements:

- A safe environment in which the child is able to feel respected and valued as you work
- An understanding of group goals and group norms
- Investment by both your facilitator(s) and members to produce a consistent group experience

A SAFE ENVIRONMENT

A safe environment is created and maintained by both the facilitator(s) of a group and its members. Primary ingredients are mutual respect and a chance to create trust. Another primary ingredient for a safe environment has to do with confidentiality. Your group facilitator(s) are bound by law to maintain confidentiality, as group members are bound by honor to keep what is said in the group in the group. We realize that you may want to share what you are learning about the child in group with a significant other. This is fine as long as you remember not to talk about how events unfold in group or in any other way compromise the confidentiality of other group members.

The facilitator(s) of the group will ask you to sign a release form so that they can talk with the individual therapist. This is a safeguard for you which allows consultation between group leaders and your individual therapist should the need arise. This also provides you with extra support should a difficult issue come up in group that may need more individual attention.

LIMITS OF CONFIDENTIALITY:

- If you are a threat to yourself or others (showing suicidal or homicidal intent), your facilitator(s) may need to report your statements and/or behaviors to family, therapist, or other appropriate mental health or law enforcement professionals in order to keep you and others safe.
- There are a broad range of events that are reportable under child protection statues. Physical or sexual abuse of a child will be reported to Child Protective Services. When the victim of child abuse is over age 18, reporting is not mandatory unless there are minors still living with the abuser, who may be in danger. Elder abuse is also required to be reported to the appropriate authorities.
- If a court of law orders a subpoena of case records or testimony, your facilitator(s) will first assert “privilege” (which is your right to deny the release of your records although this is not available in all states for group discussions). Your facilitator(s) will release records if a court denies the assertion of privilege and orders the release of records.
Records may also be released with your written permission. Records will include only your personal progress in group—not information about other group members.
- Facilitators may consult with other professionals regarding group interactions. This allows a freedom to gain other perspectives and ideas concerning how best to help you reach your goals in group. No identifying information is shared in such consultations unless a release has been obtained from you as a group member.

I have read the above information, understand the information, and agree to the terms of group participation.

Signature

Date

Social Skills Profile

Scott Bellini

Child's Name: _____
FIRST MIDDLE LAST

Birthdate: _____ Age: _____ Sex: Female Male Today's Date: _____
MO. DAY YEAR MO. DAY YEAR

School: _____ Grade: _____

Your Name: _____
FIRST MIDDLE LAST

Relationship to Child: Mother Father Guardian Other _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

The following phrases describe skills or behaviors that your child might exhibit during social interactions or in social situations. Please rate **HOW OFTEN** your child exhibits each skill or behavior independently, **without assistance from others** (i.e., without reminders, cueing and/or prompting). You should base your judgment on your child's behavior over the last **3 months**.

Please use the following guidelines to rate your child's behavior:

Circle **N** if your child **never** or **almost never** exhibits the skill or behavior.

Circle **S** if your child **sometimes** or **occasionally** exhibits the skill or behavior.

Circle **O** if your child **often** or **typically** exhibits the skill or behavior.

Circle **V** if your child **very often** or **always** exhibits the skill or behavior.

Please do not skip any items. If you are unsure of an item, please provide your best estimate. You may use the "Brief Description" section to provide additional information on the particular skill or behavior. For instance, if your child will exhibit a particular skill or behavior more frequently when cueing or prompting is provided, or when interacting with adults rather than peers, please make note of this in the "Brief Description" section.

Social Skills Profile

Never	Sometimes	Often	Very often
N	S	O	V

Skill Area	How Often				Brief Description
Invites Peers to Join Him/Her in Activities	N 1	S 2	O 3	V 4	
Joins in Activities With Peers	N 1	S 2	O 3	V 4	
Takes Turns During Games and Activities	N 1	S 2	O 3	V 4	
Maintains Personal Hygiene	N 1	S 2	O 3	V 4	
Interacts With Peers During Unstructured Activities	N 1	S 2	O 3	V 4	
Interacts With Peers During Structured Activities	N 1	S 2	O 3	V 4	
Asks Questions to Request Information About a Person	N 1	S 2	O 3	V 4	
Asks Questions to Request Information About a Topic	N 1	S 2	O 3	V 4	
Engages in One-On-One Social Interactions With Peers	N 1	S 2	O 3	V 4	
Interacts With Groups of Peers	N 1	S 2	O 3	V 4	
Maintains the "Give-and-Take" of Conversations	N 1	S 2	O 3	V 4	
Expresses Sympathy for Others	N 1	S 2	O 3	V 4	
Talks About or Acknowledges the Interests of Others	N 1	S 2	O 3	V 4	

Social Skills Profile

Never	Sometimes	Often	Very often
N	S	O	V

Skill Area	How Often				Brief Description
Recognizes the Facial Expressions of Others	N 1	S 2	O 3	V 4	
Recognizes the Nonverbal Cues, or "Body Language" of Others	N 1	S 2	O 3	V 4	
Requests Assistance From Others	N 1	S 2	O 3	V 4	
Understands the Jokes or Humor of Others	N 1	S 2	O 3	V 4	
Maintains Eye Contact During Conversations	N 1	S 2	O 3	V 4	
Maintains an Appropriate Distance When Interacting With Peers	N 1	S 2	O 3	V 4	
Speaks With an Appropriate Volume in Conversations	N 1	S 2	O 3	V 4	
Considers Multiple Viewpoints	N 1	S 2	O 3	V 4	
Offers Assistance to Others	N 1	S 2	O 3	V 4	
Verbally Expresses How He/She Is Feeling	N 1	S 2	O 3	V 4	
Responds to the Greetings of Others	N 1	S 2	O 3	V 4	
Joins a Conversation With Two or More People Without Interrupting	N 1	S 2	O 3	V 4	
Initiates Greetings With Others	N 1	S 2	O 3	V 4	

Social Skills Profile

Never	Sometimes	Often	Very often
N	S	O	V

Skill Area	How Often				Brief Description
Provides Compliments to Others	N 1	S 2	O 3	V 4	
Introduces Self to Others	N 1	S 2	O 3	V 4	
Politely Asks Others to Move out of His/Her Way	N 1	S 2	O 3	V 4	
Acknowledges the Compliments Directed at Him/Her by Others	N 1	S 2	O 3	V 4	
Allows Peers to Join Him/Her in Activities	N 1	S 2	O 3	V 4	
Responds to the Invitations of Peers to Join Them in Activities	N 1	S 2	O 3	V 4	
Allows Others to Assist Him/Her With Tasks	N 1	S 2	O 3	V 4	
Responds to Questions Directed at Him/Her by Others	N 1	S 2	O 3	V 4	
Experiences Positive Peer Interactions	N 1	S 2	O 3	V 4	
Compromises During Disagreements With Others	N 1	S 2	O 3	V 4	
Responds Slowly in Conversations	N 1	S 2	O 3	V 4	
Changes the Topic of Conversation to Fit Self-Interests	N 1	S 2	O 3	V 4	
Misinterprets the Intentions of Others	N 1	S 2	O 3	V 4	

Social Skills Profile

Never	Sometimes	Often	Very often
N	S	O	V

Skill Area	How Often				Brief Description
Makes Inappropriate Comments	N 1	S 2	O 3	V 4	
Engages in Solitary Interests and Hobbies	N 1	S 2	O 3	V 4	
Ends Conversations Abruptly	N 1	S 2	O 3	V 4	
Fails to Read Cues to Terminate Conversations	N 1	S 2	O 3	V 4	
Exhibits Fear or Anxiety Regarding Social Interactions	N 1	S 2	O 3	V 4	
Experiences Negative Peer Interactions	N 1	S 2	O 3	V 4	
Engages in Socially Inappropriate Behaviors	N 1	S 2	O 3	V 4	
Exhibits Poor Timing With His/Her Social Initiations	N 1	S 2	O 3	V 4	
Is Manipulated by Peers	N 1	S 2	O 3	V 4	
Engages in Solitary Activities in the Presence of Peers	N 1	S 2	O 3	V 4	

For more information on how to use this assessment tool in the context of teaching social skills, see S. Bellini, *Building Social Relationships: A Systematic Approach to Teaching Social Interactin Skills to Children and Adolescents with Autism Spectrum Disorders and Other Social Difficulties* ©2006; AAPC Publishing; www.asperger.net

Authorization to Bill Insurance

Client: _____ Guardian (if Minor): _____
Phone: _____ Email: _____
Address: _____
Insurance Company: _____ Policy No. _____
Doctor: BCBA Clinic: ABA Therapy Centers
Location: Online

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at the clinic named above. I therefore authorize the medical staff and personnel to release my or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

Signature

Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon service. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date