Partners in Play LLC.
Developmental Behavior Therapy Services
21010 Hawthorne Blvd. Torrance Ca 90503
424-328-0801 www.PartnersnPlayclinic.com

ABA Registration Packet

Dear Parent(s),

Thank you for choosing Partners in Play for your child's needs. We are very excited to begin working with your family. To help us develop the most accurate treatment plan as possible, please complete the documents included in this registration packet as thoroughly as possible. Please do not skip any questions, unless the question is not applicable to your child. If you plan to access your insurance benefits, **please include clear and legible copies of the *front and back* of your insurance card and your child's most recent diagnostic report(s) when submitting your completed packet.** The documents listed below may be submitted via email, fax, or by US mail.

Registration packet checklist:

- ☐ Client Information Sheet
- ☐ Program Policies
- ☐ Financial Policies
- ☐ Sick Child Policy
- ☐ Covid-19 Release of Liability
- ☐ Release/Exchange of Information
- ☐ Consent for Assessment
- ☐ Copies of previous & current providers' (SLP, OT, Psychologist, etc.) assessments, progress reports, etc.
- ☐ Copies of front and back of insurance card
- ☐ Copy of most recent diagnostic assessment report

Please let us know if you have any questions! We are happy to help!

Our very Best,

Partners in Play

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Client Information

CLIENT INFORMATION:

Child Name: _____
Address: _____
Date of Birth: _____ Age: _____ Gender: _____
Diagnosis: _____ Date of Diagnosis: _____
Diagnosed by: _____ Referred by: _____

PARENT/GUARDIAN INFORMATION:

Mother/Guardian 1 Name: _____
Address: _____
Home/Cell Phone: _____Work Phone: _____
Email: _____
Occupation: _____ Employer Name: _____
Father/Guardian 2 Name: _____
Address: _____
Home/Cell Phone: _____Work Phone: _____
Email: _____
Occupation: _____ Employer Name: _____

Parent/s are (please circle one): **single** **married** **separated** **divorced**

SCHOOL INFORMATION:

School District: _____ School Name: _____
Principal: _____
School Phone: _____
School Address:
_____
Teacher Name: _____ Grade: _____
Does your child have a current or previous IEP? _____
Does your child have a current or previous 504 plan? _____
Length of time at current school: _____

Please circle those that apply to your child:

Special Ed. Preschool Special Ed. Classroom General Ed.

School Services:

Speech therapy Occupational therapy Physical therapy Behavior Support

Frequency of School-Based Services:

Service Type :_____ for _____ minutes _____ times per week Circle: Group/Individual
Service Type :_____ for _____ minutes _____ times per week Circle: Group/Individual
Service Type :_____ for _____ minutes _____ times per week Circle: Group/Individual
Service Type :_____ for _____ minutes _____ times per week Circle: Group/Individual

REGIONAL CENTER INFORMATION:
Is your child an active client with any Regional Center? YES NO
Service Coordinator Name: _____
Phone: _____ Email address: _____
Date your child became a consumer: _____

TREATMENT HISTORY:

Previous Services Received:

Type of Service	Funding Source	Agency	Start date	End Date	Frequency

Current Services:

Type of Service	Funding Source	Agency	Start date	End Date	Frequency

SCHEDULE OF AVAILABILITY:

Please provide your child's availability for services below. Include notes as needed.
The more availability you provide, the faster we are able to assign a therapist to work with your child

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

MEDICAL HISTORY:
Medical insurance information: ***If you would like to utilize your insurance benefits, please include a front and back copy of your current insurance card when returning this packet.***

Current medical insurance: _____ Member ID#: _____
Policy Holder's Name: _____

Pediatrician Name: _____
Length of service with named Pediatrician: _____
Does your child see any other specialist regularly? (e.g., Neurologist):
_____
Address: _____ Phone Number: _____

Pregnancy, Delivery, and First Year
Were there any complications during conception, pregnancy or delivery? If so, please explain.
_____
_____
_____
_____
_____

Did your child experience any chronic or severe illnesses during the first year of life? If so, please explain.
_____
_____

Does your child currently have, or had in the past, any of the following communicable conditions? Please check all that apply:

Ear Infections Tetanus Chicken Pox Measles HIV Hepatitis TB
Other (please list):

Medical Conditions

Does your child have any diagnosed medical conditions? Please circle all that apply:

Sleep disturbances ADHD Anxiety
GI disorder Seizure disorder Depression

Genetic condition (please specify):
Other (please specify):

Please provide a history of your child's diagnoses, if any:

Diagnosis	Date	Diagnosing Physician	Comments

Medications

Please list any current medications:

Medication Name	Dosage	Start date	Reason

Please list any supplements and vitamins:

Vitamin/Supplement	Dosage	Start date	Reason

Allergies *Please list any current allergies (e.g. food, medication, etc.):*

Feeding and Nutritional *Please list any feeding concerns and nutritional needs or restrictions:*

Sleep Patterns

Please circle all that apply:

Normal Difficulty falling asleep Difficulty waking Light Sleeper

Sleep-walking Night terrors Other:_____

Bedtime: _____ Wakes: _____ Naptime: _____

Family History & Composition

Please name the child's primary place of residence and provide a list of who resides within the home. Also include a brief overview of your child's weekly schedule and who he/she spends time with on a regular basis. Please describe any family history of developmental disorders or mental illness (e.g., autism, anxiety, etc.) Write the family member's relationship to your child and his/her specific diagnosis.

Please outline your child's top three areas of strength; and identify your top three areas of concern (e.g. Concerns with transitions to non-preferred tasks, tantrums, etc.).

Strengths	***Concerns***

What immediate goals do you have for your child?

_____

What are some long-term goals you have for your child?

_____

How does your child communicate his/her wants and needs?

_____

How does your child communicate his/her emotions to others?

_____

How does your child express frustration?

_____

Does your child enjoy community outings? What are some of his/her favorite places to go?

_____

What are some of your child's favorite songs, movies, characters, and toys?

_____

How does your child spend his or her free time?

_____

_____

Please rate your child on a scale of 0 (never demonstrates the skill or behavior) to 3 (almost always demonstrates skill or behavior) across the following items:

Skill/Behavior	1 (Never)	2 (Sometimes)	3 (Always)
Able to communicate wants and needs			
Triggered by changes in routine			
Trouble accepting "no" or "not right now"			
Difficulty calming or soothing when upset			
Difficulty sitting still or staying with an activity			
Engages with a variety of toys/open to try new things			
Appears nervous or anxious			
Attends to a short story read aloud			
Shows interest in children his/her age			
Observes others and tried to imitate actions			

Program Policies

PARENT INVOLVEMENT

Partners in Play believes in a collaborative approach to treatment. Caregiver participation is required for all our families. Parent participation is also a requirement of all insurance companies. Parent training is designed to support parents and caretakers and maximize the benefits of your child's intervention program. Participation will include but is not limited to, attendance to scheduled progress meetings in the clinic setting, participation in treatment sessions, parent homework assignments, and data collection. Failure to adhere to participation requirements may result in early termination of services.

Team Meetings: Every family is required to participate in a monthly team meeting. This meeting provides an opportunity for review of your child's progress and important discussions between your family and your clinical team.

_____

Parent initials

SCHEDULING

A schedule will be developed for your child at the beginning of treatment. We ask that you maintain this schedule of availability and limit any changes to your scheduled sessions. This will allow Partners in Play to provide the total number of prescribed treatment hours for your child. Partners in Play strives to provide consistent scheduling and staff assignments for all our clients; but sometimes changes are out of our control. Partners in Play will provide as much notice as possible in the case a change to your child's schedule is required due to our staff's availability. If you require a change to your child's schedule, please discuss your needs with the program manager as soon as possible. We will make every effort to accommodate schedule changes. Make up sessions will be scheduled on request, per the client's availability and the availability of the clinical team. Make-up sessions are scheduled on a first come, first served basis and are not guaranteed.

_____

Parent initials

ATTENDANCE

Children are required to attend each scheduled treatment session and arrive on time. Parents are required to attend scheduled parent trainings, observations, and team meetings. If you child is sick and unable to attend session, or is going to be late to session, please make us aware by calling, emailing, or texting your program manager as soon as possible. Consistent attendance is mandatory in our program however, we also understand and respect your family's needs. In the event you are unable to attend multiple sessions due to a planned family vacation or other circumstances, please make us aware as soon as possible. Please note: We can hold your child's schedule for a maximum of 14 calendar days. After 14 days, we may need to re-assign staff to

another client, and we cannot guarantee your child's same schedule upon return. Make up session date(s) and time(s) will be scheduled by Partners in Play based on availability of our clinical team.

_____
Parent initials

NO SHOW/CANCELLATION POLICY

To ensure that we are able to service all individuals who are referred to us, we adhere to the following no show/cancellation policy:

1. If you cannot attend a scheduled appointment for a non-medical or health reason, please email your supervisor least 24 hours before your scheduled session. **Sessions cancelled on the same day for any non-medical or health related reason will result in a $50.00 fee.**
2. If your child is unable to attend a scheduled session for medical or health reason, please contact the office at least 3 hours prior to the appointment via telephone or email.
3. ABA is a medically necessary treatment, excessive absences for non-medical related reasons may result in disruption to client's progress and/or early termination from services. In order for clients to benefit from treatment, consistent attendance is required.
4. ABA does not follow any school district's calendar; Partners in Play will remain open during traditional breaks (winter, spring, summer). Please see our list of holiday closure dates.
5. **No show appointments will be charged a $50.00 fee.** If your child does not attend a scheduled session, or you are not home when the therapist arrives for session, and you fail to contact our office before the scheduled session start time the no show fee will apply. No show fees are due within 7 calendar days or per the due date of your next co-pay invoice, whichever date is sooner.

_____
Parent initials

TERMINATING SERVICES

1. Patients have the right to access the most effective, least intrusive, empirically based treatment services available. Guardians of patients have the right to refuse or withdrawal from treatment at any time, for any reason.
2. Patients and their families can be discharged from services for failure to comply with policies outlined in this registration packet by Partners in Play, LLC.
3. The following may result in suspension of services and/or being discharged from treatment no longer eligible for Partners in Play services.

- ✓ Past-due accounts with a balance more exceeding 90 days
- ✓ Clients are absent from 30% or more of scheduled therapy hours across a one-month period for non-medical reasons

_____
Parent initials

DATA COLLECTION
Staff will utilize the first and last 10-15 minutes of session to complete their session notes and data. Thorough data collection is required by your insurance company and essential to evaluate your child's progress and response to treatment. Clients will be provided with independent play opportunities for the last 10-15 minutes of every session.

_____
Parent initials

COMMUNICATION
Questions regarding program, scheduling, or progress updates, should be addressed in your parent meeting, or communicated with the program manager. Therapeutic staff do not have the authority to approve program updates or scheduling changes.

_____
Parent initials

COMMUNITY OUTINGS
All community-based treatment sessions must be approved prior to session by the Clinical Director. Community outings must reflect the objectives of current program goals. Parents/Caretakers must accompany staff and clients on ALL community outings. Parents must be present and available for the duration of the community outing. Partners in Play is not allowed to transport any clients in their vehicles, or ride in a client's car. Community outings must be scheduled within the duration of your regularly scheduled home sessions, unless otherwise scheduled with the program manager.

_____
Parent initials

DIETARY RESTRICTIONS
For children with food allergies and/or dietary restrictions, we ask that parents complete a dietary form prior to the first session. Staff will ensure this information is kept on hand during your child's session for safety. Please notify your program manager regarding your child's allergy and/or food restriction.

_____

Parent initials

DIAPERING & TOILETING
Parents will provide Partners in Play with diapering supplies (diapers, wipes, change of clothes), as needed, to utilize during the child's session. Partners in Play staff will facilitate diaper and clothing changes as needed. Please provide us with an extra set of clothes in case of bathroom accidents and/or activities in which your child may get dirty/messy.

Please initial here to acknowledge consent of diaper and clothing changes: _____.

Medication
Partners in Play does not dispense medication to our clients. If your child has a severe allergy that requires emergency medication, please inform, and consult with a supervisor.
Please note: Partners in Play is not a peanut free environment*

_____
Parent initials

Financial Policies

To ensure you are familiar with our financial policies and your financial responsibility, we have prepared this information for your review.

Insurance Benefits
1. Prior to an initial intake and evaluation, a Partners in Play associate will contact your insurance company to verify insurance coverage and benefits eligibility.
2. If benefit coverage for ABA is verified, an associate will complete the process as designated by your insurance, to receive authorization for an initial assessment
3. If intervention services are recommended as a result of the initial assessment, staff will contact your insurance company to obtain authorization for treatment services.
4. To protect you from unexpected charges, services will not be rendered until we have received all required authorizations from your insurance company.

_____
Parent initials

Accessing Medical Benefits for Applied Behavior Analysis:

1. Prior to beginning services clients are advised to contact and verify their insurance policy's mental or behavioral health benefits specifically for Applied Behavior Analysis services.
2. Contact your insurance company to request information on any deductible, co-insurance, out-of-pocket expenses, co-pays or financial responsibilities related to ABA services.
3. Partners in Play will complete an insurance verification process to verify your benefits and coverage. Partners in Play will communicate information regarding expected out of pocket costs to you prior to beginning treatment. We do not guarantee this information is accurate and will not be held responsible in the event out of pocket costs total more than expected. The policy holder is responsible for any and all authorized charges not covered by insurance.
4. During your initial intake meeting we will re-review insurance benefits
5. Throughout the course of treatment clients are responsible for maintaining their insurance benefits and informing Partners in Play in advance of ANY changes, such as:

a. Employment changes
b. Employer health benefit plan changes
c. Lapse in coverage

If your insurance is discontinued or you have a lapse in coverage for any reason, you will be financially responsible for all services provided at the negotiated provider rate (if applicable) or private pay rate, whichever is cheaper.

_____
Parent initials

Payment Responsibility and Late Fees

1. Partners in Play does not offer credit or payment plans for co-insurance, deductibles, or co-pays. The policy holder is responsible for all copayments, deductibles, co-insurance, and any charges for non-covered services.

   As a courtesy and for your convenience, Partners in Play provides the policy holder with an invoice for co-pay, co-insurance, and deductible costs that apply at the end of each month. Policy holders are responsible for reviewing their Explanation of Benefits (EOB) and remaining knowledgeable regarding their cost responsibilities. The policy holder is responsible for their portion of treatment costs at the time services are rendered. For this reason, invoices are due upon receipt. Partners in Play, LLC accepts cash, personal checks, debit cards, and all major credit cards. Checks should be made out to Partners in Play, LLC.

If your payment is not received in full within 5 calendar days from the date of your invoice, a $25.00 late charge will apply.

Payments made 14 calendar days late will be charged a $50.00 late fee.

Payments made 30 or more days late will be charged a $75.00 late fee.

If your account has an outstanding balance for 60 days or more, treatment sessions will be placed on hold until payment is received in full. Following the conclusion of a maximum 14 calendar day hold, your child will be discharged from treatment and your outstanding balance will be forwarded to a collection agency.

**** Please note ***
Checks returned for insufficient funds ("NSF") will be assessed a $30.00 returned check fee.

By initialing below, I understand that any co-pay, co-insurance, and deductible amounts are my responsibility to pay at the time services are rendered. I also understand that it is my responsibility to remain current on my insurance policy, coverage, and benefits. Failure to remit timely payment for invoices will result in late fees assessed and may impact my child's access to services provided by Partners in Play.

_____
Parent initials

Insurance Billing

1. By initialing below, you authorize Partners in Play to bill your insurance company for services rendered. Claims billed to your insurance have various processing timelines ranging from 45-60 days. Claims may not be processed for an extended time following the start of treatment. It is the client's responsibility to be aware of all out of pocket costs. Please maintain consistent contact with insurance regarding potential costs related to claims for ABA services.
2. Partners in Play will bill your current medical insurance per the information you provided. You are financially responsible for any copayments, coinsurance and/or deductibles, out-of-pocket expenses and any related services as indicated by the explanation of benefits and/or explanation of payment provided by your insurance.
3. Any ABA related treatment service rendered will be considered verified by one of the following forms of documentation: caretaker's signature/initials, authorized adult signature/initials, staff signature/initials, data collection and/or supervision notes generated from case management (including but not limited to email exchange).

_____
Parent initials

By signing below, you acknowledge you have read, understand, and will adhere to the policies outlined above by Partners in Play LLC.

Child's Name: _____ Child's DOB: _____

Parent Print Name: _____ Parent Signature: _____

Date: _____ Member ID Number: _____

Please include a front and back copy of your current medical insurance card, thank you!

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Sick Child Policy

Our sick child policy was developed to protect the health of your child and family, the health of other children who receive services at our center and the health of our staff. **We appreciate your strict adherence to this policy.**

Policy: A parent must cancel therapy whenever their child exhibits any one of the following symptoms *within the last 24 hours*:

- A temperature of 100 degrees or higher
- Diarrhea (2 occurrences)
- Vomiting (1 occurrence)
- Any rash other than diaper rash
- Eye infection
- Sore throat
- Cold symptoms with dry, persistent, or productive cough or persistent nasal discharge

✓ If your child, or anyone in the household is experiencing symptoms of a highly contagious disease, such as **COVID-19, Pink eye, Strep throat, Head lice, Impetigo, or Hand-Foot-Mouth Disease,** sessions should be canceled.

✓ We will use our discretion in deciding whether therapy should continue if a child appears to be feeling ill during a clinic or home session.

✓ Our staff are instructed to cancel a session if they have the potential to expose your child to an illness.

✓ Children must be fever-free for 24 hours, without the use of medication, before returning to therapy

Please see our attendance policy for more information regarding make-up sessions.
By signing below, I acknowledge that I have read and understand the sick policy outlined above. I commit to following these policies to protect the health and well-being of my child, as well as other children serviced by Partners in Play.

_____ _____
Parent/Guardian Signature Date

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Authorization to Release and/or Exchange Confidential Information

Client Name: _____ Date of Birth: _____

This is to authorize the release and/or exchange of confidential information between Partners in Play and other individuals and/or agencies listed below:

Agency/Individual: _____ Phone: _____
Agency/Individual: _____ Phone: _____
Agency/Individual: _____ Phone: _____

Please initial each category of specific information that you are allowing be releasing and/or exchanging. Write 'NO' in categories of information that you are not allowing to be released.

_____Psychological and/or psycho-diagnostic assessment
_____Psychological testing results
_____Psychiatric and psychological counseling record
_____Medication history and medication record
_____School assessments and evaluations (IEP)
_____Speech and Language assessments
_____Occupational therapy assessments
_____Treatment plans
_____Consent for observation at the named agency's site
_____Specify any additional information to be obtained and/or released:

I understand that I have right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be received in writing by all providers to be effective. I understand that I have the right to revoke this authorization at any time unless the provider has acted in reliance upon it. The provider shall not condition treatment upon patient signing this authorization and patient has right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information. A copy of this form is as valid as the original. This authorization is valid for one year following the date of signature unless otherwise specified.

_____ _____
Parent/Guardian Signature Date

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Holiday Schedule 2025

Partners in Play does not follow a typical school schedule. We provide a medically necessary service and will be closed only on the dates listed below.
Should you need to cancel your child's sessions for additional dates/holidays not listed below, please provide our office with at least a 24-notice.

New Year's Day	Thursday, January 1, 2026
Memorial Day	Monday, May 26, 2025
Independence Day	Friday, July 4, 2025
Labor Day	Monday, September 1, 2025
Thanksgiving	Thursday, November 27 through Saturday November 29, 2025
Winter Break	Wednesday, December 24 through Friday, December 26, 2025

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Consent for Initial ABA Assessment

Child's Name: _____ Date of Birth: _____

By signing below, I authorize Partners in Play to complete a comprehensive initial assessment for my child to determine eligibility for ABA treatment services. The assessment report will include results from one or more standardized assessments, observational notes and data, an individualized treatment plan and the prescribed number of treatment hours. This assessment will be completed by a Board-Certified Behavior Analyst (BCBA). I understand this consent is for an assessment only and does not provide Partners in Play with permission to implement the recommended services. I understand that I have the right to refuse or discontinue assessment services at any time, for any reason, by providing a written or verbal request.

The BCBA will conduct an assessment for your child composed of four in-person or virtual appointments. Appointments may be scheduled at your home, in our clinic, or in the community setting. Your specific assessment schedule will be provided to you once authorization for the assessment has been obtained from your insurance company.

Please see below for a brief overview of the 4-step assessment process:

1. Parent Interview
2. Indirect assessment
3. Direct observation & assessment
4. Assessment review meeting

Parent Name: _____ Date: _____

Parent Signature:_____

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Consent for Initial Social Skills (only) Assessment

Child's Name: _____ Date of Birth: _____

By signing below, I authorize Partners in Play to complete a social skills assessment for my child to establish goals to target social-emotional development. The assessment report will include results from parent interview/report, observational notes and data, and an individualized treatment plan including goals specific to my son or daughter's area(s) of need. This assessment will be completed by a Board-Certified Behavior Analyst (BCBA). I understand this consent is for an assessment only and does not provide Partners in Play with permission to implement the recommended treatment goals. I understand that I have the right to refuse or discontinue assessment services at any time, for any reason, by providing a written or verbal request.

The BCBA will conduct an assessment for your child composed of three in-person or virtual appointments. Appointments may be scheduled at your home, in our clinic, or in the community setting. Your specific assessment schedule will be provided to you once authorization for the assessment has been obtained from your insurance company.

Please see below for a brief overview of the 3-step assessment process:

1. Parent Interview
2. Direct Assessment/Clinic Visit
3. Assessment Review Meeting

Parent Name: _____ Date: _____

Parent Signature:_____