Innovative Care Network

" Exceptional People, Exceptional Care"

New Patient Enrollment Packet

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Dear Families,

We are thrilled to welcome you to Innovative Care Network's ABA Therapy and Behavior Interventions program! It is our pleasure to embark on this journey with you and your family as we work together to support the growth, development, and well-being of your child.

At Innovative Care Network, we understand the unique challenges and joys that come with raising a child with autism spectrum disorder (ASD) or related developmental disabilities. Our dedicated team of professionals is committed to providing compassionate, evidence-based interventions that are tailored to meet the individual needs of each child and family.

As part of our ABA Therapy and Behavior Interventions program, your child will have access to a comprehensive range of services designed to promote positive behavior change, enhance communication and social skills, and improve overall quality of life. Our team of experienced Board-Certified Behavior Analysts (BCBAs), behavior technicians, and support staff will work closely with you to develop and implement personalized treatment plans that address your child's specific goals and challenges.

We believe in the power of collaboration and open communication, and we welcome your active involvement in your child's care. Together, we will celebrate milestones, overcome obstacles, and celebrate the unique strengths and abilities of your child.

In addition to our direct intervention services, Innovative Care Network is committed to providing resources, support, and guidance to help you navigate the complexities of raising a child with autism. Whether you have questions about accessing community resources, advocating for your child's educational needs, or managing everyday challenges, our team is here to assist you every step of the way. We are truly honored to

be a part of your child's journey, and we look forward to getting to know your family and working together to achieve meaningful and lasting outcomes. If you have any questions or concerns, please do not hesitate to reach out to us at any time.

Thank you for entrusting us with the care of your child. We are excited to begin this partnership and make a positive difference in your lives.

Warm regards,

Kianna Chapman
CEO
Innovative Care Network
info@innovativecarenetwork.com
(919)664-4534

What is ABA?

Applied Behavior Analysis (ABA) is an evidence-based approach to creating meaningful or socially significant behavior change. New skills and behaviors are taught while existing behaviors are modified. ABA focuses on behaviors that are observable and measurable, with respect to their function. This is determined through the collection of data that involves antecedents and consequences, which are events that occur directly before and after the behavior of interest. This approach utilizes principles of reinforcement, to increase skills that are functional and socially significant throughout the child's daily life. ABA not only teaches these skills, but also promotes maintenance and generalization of the skills. ABA also serves to decrease behaviors that may interfere with learning, such as tantrums, aggression, or stereotypy. Treatment plans are developed to facilitate learning based on the individualized need of each child. Areas that we work on include (but are not limited to):

- **Language and Functional Communication**: Communicating needs/wants to others
- **Independent Play**: Playing alone without assistance
- **Social Skills**: Interacting with others
- **Imitation**: Imitating behaviors or vocalizations of others
- **Gross/Fine Motor Skills**: Control over balance and body movement
- **Listener Responding**: Attending and responding to spoken words
- **Visual/Perceptual Skills**: Interpreting things he/she sees visually
- **Self-help Skills**: Skills such as dressing, grooming, feeding, toilet training

What Is Required To Start ABA Services?

1. Completed Intake Packet: any other evaluations or reports would be helpful
2. Intake Interview
3. If insurance is involved then pre-authorization is required prior to any evaluation, therapy or other services being provided
4. Assessments completed by ICN Innovative Care Network staff and parents
5. Meeting with Clinical Supervisor to discuss treatment goals and program plan
6. Arrangement of therapy schedule

Types of Services Innovative Care Network Provides

Home based 1:1 Therapy

To ensure all skills are generalized and parents and family members are able to successfully implement the plan at home, in-home based services will be recommended.

Functional Behavior Analysis (FBA)

This is designed for children who may have behaviors that are interfering with their ability to learn. An analysis of the behavior of concern will be completed via parent interview and direct observation. Once the analysis is conducted, a plan will be written to address the behaviors of concern.

Parent Training

All ABA services include a component of parent training. In order for ABA therapy to have lasting effects, parents must assist the child with bringing the skills he or she learns to other natural environments, especially in the home and community settings. Parent education and training will be available through Innovative Care Network. Participation by parents, guardians, or caretakers is not only encouraged but expected for any program to be successful.

Assessments We Use

ABLLS-R:
The Assessment of Basic Language and Learning Skills *Revised* is a criterion-referenced assessment protocol that is used to assess the language, academic, self-help, and motor skills of children with ASD and other developmental disabilities. The purpose of the assessment is to develop an individualized curriculum and skills tracking system. It provides a task analysis of skills, breaking each skill down to the separate components necessary to perform the skill adequately.

FBA:
The Functional Behavioral Assessment Functional Behavior Assessment is the primary tool used to identify and attempt to understand a child's behavior. It is used to develop strategies and interventions to address the problem behaviors. The process identifies the specific target behaviors and the purpose of the behavior.

VBMAPP:
The VB-MAPP is a criterion-referenced assessment tool, curriculum guide, and skill tracking system that is designed for children with autism, and other individuals who demonstrate language delays. There are five components of the VB-MAPP: Milestones, Barriers and Transition Assessment, Task Analysis and Skills Tracking and Placement and IEP Goals. They provide a baseline level of performance, a direction for intervention, a system for tracking skill acquisition and a tool for outcome measures.

Financial Information

Innovative Care Network is willing to participate with any major insurance provider in the State of North Carolina. Please contact us to find out if we are currently providers for your insurance company.

All fees are based on the service performed including copays.

Rules and Regulations

Scheduling And Sessions

Sessions for ABA therapy are typically scheduled in 2-3 hour blocks. The research demonstrates that longer sessions result in greater retention of skills and mastery is sustained.
The parent or legal guardian is not required to be present during the therapy session but should arrive 10 minutes prior to the end of the session for consultation with the therapist.
Please provide 30 days notice on significant changes to ABA scheduling in order to facilitate consistency in service delivery. This may include a request for change in schedule, long vacation, or termination of services.
Sessions will involve direct services with the client, time to prep materials, data collection, and time to discuss the session with the parent.

Absences, Vacations And Holidays

1. I/We understand that in the event of inclement weather, all programs at Innovative Care Network will follow the local public school's procedures. I/ We further understand that the Agency Owner/CEO and Regional Clinical Director has the discretion to cancel appointments due to exigent circumstances if needed even if the schools have not closed.

2. Innovative Care Network (ICN) has scheduled in-iservice days and holidays where all services will be canceled. I/We understand that we will be provided with a calendar of those scheduled days in advance.

3. I/We understand that requests for leaves of absence or extended vacation from the program must be submitted with at least 30 days' notice and will be reviewed by the Regional Clinical Director. Upon approval, arrangements will be made on a case by case basis.

Illness Policy

1. I/We understand that if my child's temperature is at or above 100 degrees I/we will be contacted and that my/our child will be required to be picked up.

2. I/We understand that my child must be fever free for a minimum of 24 hours before returning to therapy, without the aid of any fever reducing substance.

3. I/We understand that I/we will be called to pick up my child from therapy or home therapy sessions ended, if he/she has two (2) or more unexpected instances of diarrhea. I/We understand that my/our child will not be permitted to resume therapy until 24 hours have passed with no diarrhea instances.

4. I/We understand that I/we will be called to pick up my child from therapy or home therapy sessions ended, if he/she has one (1) or more instances of vomiting. I/We understand that my/our child will not be allowed to resume therapy until 24 hours have passed with no instances of vomiting.

5. I/We understand that I/we may bring my/our child to therapy if he/she has a common cold (slight occasional cough, clear runny nose, occasional sneezing). I/we further understand that if my/our child has discharge of any other color than clear, my/our child will not be seen for therapy.

6. I/We understand that if my/our child has any rash other than a mild diaper rash I/we must bring a not from the doctor stating the rash is not contagious.

7. I/We understand that by law my/our child is not permitted to be seen for therapy if he/she has contracted a communicable disease. Examples of communicable diseases are (but not limited to): Conjunctivitis (Pink eye), Impetigo, Hepatitis A, Scabies, Ringworm, Infections Diarrhea, Chicken Pox, Scarlet Fever, Lice, and Strep Throat. I/we understand that if my/our child is thought to have a communicable disease I/we will be contacted and that my/our child will not be permitted to be seen for therapy. I/we further understand that my/our child will not be permitted to attend therapy until a doctor's note has been provided stating that my/our child is no longer contagious.

Observation Of Client

1. I/We understand that my/our child could be videotaped while receiving therapy from Innovative Care Network for the purpose of training staff members and/or receiving video updates on

my/our child's progress. I/We understand that any video will be kept confidential.

2. I/We understand that professionals, other clients, potential clients, staff, and therapists in training will occasionally be observing therapy. In these cases, I/we will be informed of the purpose of the observation.
3. I/We understand that I/ We may view my/our child while he/she is receiving therapy. In addition, I/we may be asked to observe procedures in order to promote generalization.

Medical Information

1. I/We understand that I/we have agreed to release my/our child's medical and psychological records to Innovative Care Network. Releasing these records will allow us to review my/our child's diagnosis, developmental, medical, levels of intellectual, behavioral, and social functioning as well as their medical history.

2. I/ We understand that I/we give Innovative Care Network permission to seek medical assistance for my/our child in case of an emergency. Medical attention will be sought without my/our verbal permission if I/we are either unreachable, time is of the essence, or other unforeseeable circumstances arise.

3. I/we understand that there are medical conditions, as well as certain medications (such as insulin), that the staff of Innovative Care Network is not qualified to deal with and/or administer. If a medical condition arises that the staff is NOT able to handle, my child may not be able to be seen by the staff.

Cancellation Policy and Fees

If written notice for cancellation of a session is not received 24 hours prior to the scheduled session, documentation for a no call/no show will be applied. If more than 3 no call/no shows are documented, the fourth and any cancellation thereafter will result in a $50.00 fee. This ensures consistent and quality service is provided to our clients.

Signature Agreement for Rules and Regulations of Innovative Care Network:

_____ _____

Signature (Parent/ Guardian) Date

Release Form

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL AND MENTAL HEALTH RECORDS AND INFORMATION

SOURCE OF INFORMATION
Person or facility: _____
Address: _____
_____Phone # _____
IDENTIFYING INFORMATION
Name:_____
Address: _____

Phone #: _____DOB:_____Social Security #:_____
Parent/Guardian:_____
Address: _____
_____Phone # _____
I hereby authorize the source named above to send the records marked below to Innovative Care Network at the address listed above.
____Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness:
____ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by and staff member or by the client.
____Psychiatric evaluations, reports, or treatment notes
____Treatment plans, recovery plans, aftercare plans
____Admission and discharge summaries
____Social histories, assessments with diagnosis, prognoses, recommendations, and all similar documents
____ Information about how the client's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.
____Workshop reports and other vocational evaluations and reports.
____Billing records
____Academic or educational reports
____Report of teachers/staff observations
____Achievement and other test results
Other: _____

I further authorize the source named above to speak by telephone with staff of Innovative Care Network about the reasons for my/the client's referral, and the relevant history or diagnosis, and other

similar information that can assist with my/the client's receiving treatment or being evaluated.

_____ _____

Signature Printed Name

Service Agreement and Consent Form

This document contains important information about our professional services and business policies. It also contains summary information about the Health Information and Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPPA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with the information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

Services Offered

We will provide services specifically designed to help you and/or your minor child, or otherwise provide you with referrals to other professionals. Our behavioral services consist primarily of individual behavioral and skill assessments and short and long-term ABA service provision to youth in the autism spectrum but are not limited to those areas.

Appointments

Except for rare emergencies, we will see your child at the time scheduled. We understand that circumstances (such as illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you give us as much notice as possible. This will allow us to offer your time to another person. You will be charged the standard hourly rate (see below) for appointments missed or canceled with less than 24 hours' notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges. 75% attendance is required to maintain services. 3 or more no call/no shows will result in termination of services.

Confidentiality, Records, and Release Of Information

All services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions mandated by North Carolina and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

To Protect Client From Harm

If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this and any additional information upon request to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, an intended victim, a minor's parents, or others who could provide protection, or seek appropriate hospitalization.

Professional Consultations

Behavior Analysts routinely consult about cases with other professionals. In doing so, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them.

Records

We will review all testing results during our feedback session, and offer you opportunities to ask questions and discuss the results with us. You will receive a written report that summarizes the findings. This report will include a summary and interpretation of all individual testing, as well as impressions from individual observations and consultations conducted as a part of a comprehensive individual evaluation. Upon your request, we are happy to provide you with a written summary of our impressions from other meetings, consultations, or observations as well.

Payment For Services

If necessary, we may seek assistance from an outside party in order to collect payment for services rendered to you. In such cases, any disclosures are limited to the minimum that is necessary to achieve the purpose. Copays are the responsibility of the beneficiary.

Health Care Insurance

If we do not file your insurance claims at this time, we will provide you with statements that you may submit to your insurance carrier or complete any forms as required by your insurance carrier in order to obtain reimbursement for out-of- network providers. In order to assist you with obtaining reimbursement for our services, your insurance carrier may require that we provide a clinical diagnosis, or additional clinical information such as treatment plans or summaries, copies of your child's entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you and your child that is necessary for the purpose requested. By

signing this Agreement, you agree that we can provide requested information to your carrier if/when you choose to file a claim for any services that we have provided to you or your child.

Professional Records

You should be aware that, pursuant to HIPPA, we keep clients' Protected Health Information in two sets of professional records. One set contains the Clinical Record and the other the professional's personal notes.

Client Rights

HIPPA provides you with several rights with regards to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your records; requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about your policies and procedures recorded in your records; and the right to a paper copy of the Agreement; the attached Notice Form, and our privacy policies and procedures.

Contacting Us

Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends). If you are difficult to reach, please leave some times when you will be available.

Consent

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPPA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

_____

Client/Child's Name Date

_____

Parent/Guardian #1 Name Parent/Guardian #2 Name

_____

Parent/Guardian #1 Signature	Parent/Guardian #2 Signature

Client Confidentiality Contact Form

Client confidentiality is a top priority for Innovative Care Network. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.
In the event that I,_____, am unable to be reached, Innovative Care Network may leave information with the following:

_____Other Adult in Household (Name):_____
_____On Home Voice Mail (#): _____
_____On Cell Phone (#): _____
_____I may be reached at my work number: _____
_____May leave a message at work on my voicemail: _____
_____Other: (Please describe): _____
_____Text:_____

OPT OUT (Initials)_____. In the event that I am unable to be reached, Innovative Care Network (ICN) MAY NOT leave information with anyone but myself. I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of Innovative Care Network (ICN).

Parent's Signature:_____Date: _____

Informed Consent For Services

I,_____, as a parent or guardian, give my consent for Innovative Care Network (ICN) to provide behavior analytic services to my child,_____, in accordance with the ethical guidelines proposed by the Behavior Analytic Certification Board (BACB). I also understand that I may withdraw my consent and terminate treatment at any time and for any reason.

I understand that any information provided in this intake as well as any information obtained at any point during the interview process or course of treatment, is kept strictly confidential in accordance with HIPAA regulation guidelines and the law.

I understand that Board Certified Behavior Analysts are bound to strict ethical guidelines of practice and that any issues of concern that may arise throughout the treatment process that are out of the behavior analyst's area of experience may result in referrals to a more appropriate agency or individual.

Signature:_____Date:_____

Printed Name:_____Name of Client: _____

Release, Indemnification and Hold Harmless Agreement for Transportation

As a necessary and indispensable part of my being allowed to participate in, community outings, field trips, and other necessary transportation sponsored by Innovative Care Network (ICN), I do hereby agree and represent, on my behalf and on behalf of my heirs, personal and legal representatives, successors, assigns, employees, dependents, and associates as follows:

I ,_____willingly assume any and all risks and danger inherent with or incidental to myself and my minor child,_____participation in all sessions and travel to and from community locations, or classes, and any and all activities in connection with any such activities sponsored by Innovative Care Network (ICN).
I understand and accept that accidents occur, although Innovative Care Network (ICN) will make every attempt to maintain the utmost safety for all parties involved. In any event and regardless of the nature of any injury, damage, or loss that I may suffer or that may accrue to the benefit of or damage to any of the persons named above, no claim or demand will be made on or against you, Innovative Care Network (ICN) or on or against any of the agents, representatives, associates, employees, or contractors of Innovative Care Network (ICN).

I give permission for my child to be transported to and from the below activities by staff or contractors of Innovative Care Network (ICN):

_____School
_____Community Outings
_____Field Trips
_____Medical Needs (Clinics/ER/Hospital)
_____Other

This agreement is knowingly, willingly and freely given, and I fully understand and agree that it is a release and waiver of certain rights I may have and shall act as a complete bar against any claims that might otherwise be brought.
I have been given a copy of this agreement, which I have read and I understand and acknowledge its terms. Its contents have also been explained to me. I understand the consequences of my signature to this agreement.

Signature of Parent:_____Date:_____
Print Name: _____

ABA Therapy Intervention Intake Form

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding your child. Innovative Care Network (ICN) will hold information provided by you as strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law.

PLEASE PRINT

Person Completing this Form

Name: _____ Please indicate relationship to the client: ☐Parent ☐ Guardian ☐ Other:_____

Are you authorized to consent for this individual's healthcare? _____ No _____ Yes

Client Information

Client Name: _____,

_____

Date of Birth: _____ / _____ / _____

Address:

_____

_

Please answer the following questions about the child's living situation:

A. Are the child's parents Divorced/Separated? _____ No _____ Yes

1) If Divorced/Separated:

Who is responsible for making medical decisions for the child? _____ Joint _____ Sole

If sole custody, please specify which parent: _____

With whom does the child reside? _____

B. Household 1: _____% time

Name of Parent or Guardian #1: _____

Name of Parent or Guardian #2: _____

Names and ages of any other siblings:

_____

_____

F. Primary Language: □ English □ Other: specify _____

Percent time child is exposed to non-English language(s): _____%

Previous Evaluations/Assessments

Please list any school testing and/ or other evaluations of the client's skills.

1. Has the client ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist,
Psychiatrist, Psychologist, Special Educator, or other mental health counselor? ____ No ____ Yes ___ Unknown
If yes, please provide the following information:
A. Name: _____ Type of Specialist_____Date of evaluation: _____
Purpose of Evaluation / Services: _____
Results of Evaluation:
_____
_____
B. Name: _____ Type of Specialist_____ Date of evaluation: _____
Purpose of Evaluation / Services: _____
Results of Evaluation:
_____
_____
C. Name: _____ Type of Specialist_____ Date of evaluation: _____
Purpose of Evaluation / Services: _____
Results of Evaluation:
_____
_____

Educational History

Please list the schools attended from most recent.
1. Is the client currently enrolled in school or Birth-3 Services? ___ No ___ Yes ___ N/A
School Name: _____ School District: _____
Program or Grade level:
_____
2. Please list any other schools that the client has attended:
A. School Name: _____ School District: _____
Years of attendance: _____ Grade Levels: _____
B. School Name: _____ School District: _____
Years of attendance: _____ Grade Levels: _____
C. School Name: _____ School District: _____
Years of attendance: _____ Grade Levels: _____
3. Is the client receiving or has the client received special services or accommodations at school? ____ No ____ Yes
If yes, please explain what type: (e.g. IEP, IFSP, 504 Plan)
_____

Client/Child's Interests

Please indicate anything that the clinicians should know when working with him/her.

1. Preferences (favorite activities, food, interests/topics, sensory):

2. Dislikes (aversions):

Concerns

1. Reason for seeking ABA Services [Please explain]:

2. Please list client strengths:

_____

3. Developmental Concerns [Please indicate by marking the box and explaining each domain]

☐Cognitive/Learning ☐Motor

☐Behavior ☐Language

☐Social ☐Peer Interaction

☐Play/Leisure ☐Self-Help (Dressing/Toileting/Feeding/Etc.)

☐Dietary/ Allergies ☐Other

☐Academics (Reading/Writing/Math) ☐Executive Functioning (Organization/Flexibility/Attention)

Description of Services

Applied Behavior Analysis (ABA) Intervention Services: Behavior and Education Consultants (BCBAs) provide evidence-based treatment using Applied Behavior Analysis (ABA) strategies to teach new skills, develop meaningful learning tasks, address challenging behavior, and support individuals with autism in a variety of settings.

⇨Client-Focused Skills Coaching: BCBAs work directly with the client to build specific skills. This type of therapy is only appropriate when recommended by your BCBA and may not be the best fit for all clients.

⇨Intensive In-Home ABA Program: The BCBA works with families to develop, implement, and refine an in-home, intensive, comprehensive ABA-based programs individualized for each child. Home-based programs are implemented by behavior technicians and supervised by the BCBA.

Hours of Availability

Please mark the times you and the client **ARE** available for services.
Monday |Tuesday |Wednesday |Thursday |Friday
(Example: Monday-Friday 8:00-4:00 or Monday-Friday 9:00-5:00)

Additional Comments

_____
_____
_____
_____
_____
_____
_____

Cultural Considerations
Please describe below important cultural practices, rituals, traditions or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship.

_____
_____
_____
_____
_____

Please attach a copy of your insurance card (front and back)
☐Check that a copy of each side is included with this packet
Please attach a copy of your child's reports (please include all that apply):
☐Diagnostic Evaluation Report (Required)
☐IEP/IFSP/504 Plan (Optional)
☐Functional Behavior Assessment (FBA) /Behavior Intervention Plan (BIP) (Optional)
☐Prescription for ABA (Optional)
☐Mental health directives (Optional)
☐Medical advance directives (Optional)
☐Powers of attorney (Optional)
☐Discharge summaries or evaluations from any and all inpatient/outpatient services within the last 5 years (Optional)
☐Least restrictive alternative orders (Optional)
☐Other: _____
Coordination of Care (Optional)

Please list and provide contact info for all other providers for your child:
☐Primary care provider: _____ Contact:
☐School teacher: _____ Contact:
☐Speech Language Pathologist: _____ Contact:
☐Occupational Therapist: _____ Contact:
☐Other: _____ Contact:

Please list any medications your child is taking, the purpose of the medication, dosage and any concerns:
_____

INSURANCE BILLING INFORMATION and AUTHORIZATION

◯ I am a private pay client and acknowledge it is my personal responsibility to pay for services.
- o Board Certified Behavior Analyst hourly fee is $152 per hour for assessments, consultations,supervision, meetings, and therapy.
- o Applied Behavior Analysis Behavior Technician fee is $54 per hour.

◯ I authorize my insurance provider(s) listed below to make payments directly to Innovative Care Network for services rendered.

◯ I understand that a copy of my insurance card (front and back) will be retained in my client/patient file for billing purposes.

◯ I agree that private information may be shared with my insurance carrier for billing purposes.

◯ I understand that if I do not want information shared that I may submit specific direction to Innovative Care Network.

Name of Primary Sponsor: _____SS # _____
Name of Insurance Carrier _____Policy # _____
Name of Secondary Sponsor: _____ SS # _____
Name of Insurance Carrier _____Policy # _____
Medicare/Medicaid Identification#_____

PATIENT / CLIENT SUPPLEMENTAL INFORMATION

Has the client or any family member been court ordered to mental health or chemical dependency treatment?

◯ Yes ◯ No

If Yes, please provide details and a copy of the court documents:

_____

_____

_____

_____

Is the client or any family member under department of corrections supervision?

◯ Yes ◯ No

If Yes, please provide details:

_____

_____

_____

_____

Does the client and/or family member have a history of substance abuse, including tobacco?

◯ Yes ◯ No

If Yes, please provide details:

_____

_____

_____

_____

Does the client and/or family member have a history of pathological gambling?

◯ Yes ◯ No

If Yes, please provide details:

_____

_____

_____

Has the client been identified to be at risk of harm to self and/or others, including suicide and/or homicide?

◯ Yes ◯ No

If Yes, please provide details:

_____

Does the client have any history of trauma or abuse?

◯ Yes ◯ No

If Yes, please provide details:

_____

_____

Parent / Family Preferences

Please list the top three areas/goals you would like to see improvement for the client in next 6 months:

1.

2.

3.

Developmental History

Please indicate the age at which your child did the following:

Milestone	Age
Rolled over consistently	
Sat up unsupported	
Stood	
Crawled	
Walked unassisted	
Said 1st word intelligible to strangers	
Said two-three word phrases	
Used sentences regularly	
Toilet trained during the day	
Dry through the night (6+ months)	
Dressed self	
Fed self	
Colored	

Social Skills

Please indicate if your child is experiencing any of the following:

ISSUE	√ or X	COMMENTS
Plays independently		
Plays with toys appropriately		
Attempts to involve others in play		
Engages in interactive play with peers		
Engages in pretend play		
Spontaneous vocalization/language		
Imitates sounds/words/phrases		
Communicates wants/needs		
Follows simple directions		
Labels items/events/actions		
Answers WH questions		
Engages in verbal exchanges with others		
Imitates simple gestures (fine motor)		
Imitates simple gestures with objects		
Imitates gross motor skills		
Problems making/keeping friends		
Problems getting to/staying asleep		
Problems controlling temper		
Problems with authority		
Anxiety		
Unmotivated		
Concentration difficulties		

Self – Care

How well does your child complete each of the following?

TASK	INDEPENDENT	SOME HELP	FULLY ASSISTED
Dressing			
Eating			
Drinking			
Toileting			
Brushing Teeth			
Washing Hands			

Daily Routines

Describe your child's basic daily routine (include times to wake up, naps, bedtime, meals, school, etc.

TIME OF DAY	DESCRIPTION OF ROUTINE
Morning	
Afternoon	
Early Evening	
Night	

List any serious operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had:

_____

_____

_____

Allergies

Please circle any of the following conditions that your child has had:

Allergic reactions	**Earaches**	**Hives**	**Broken bones**
Ear infections	**Itchy eyes**	**Constipation**	**Eczema**
Seizures	**Dehydration**	**Heart problems**	**UTI**
Diabetes	**Hemorrhoids**	**Other**	**Other**

Medications

List any medications your child is currently taking or has taken for extended periods:

MEDICATION	PURPOSE	DOSAGE	DATES

Is your child on a special diet? Yes No If yes, please explain:

_____

_____

Which hand does your child write/hold a pencil with?Right Left No dominance shown

Does your child have any vision problems? Yes No
Please list the date of the last vision test and who performed (pediatrician, optometrist, school)

_____

Does your child have any hearing problems? Yes No
Please list the date of the last hearing test and who performed (pediatrician, audiologist, school)

_____

Name of child's physician (s): _____
Practice name: _____
Address: _____
Phone number:__-___-_____

Related Services

Service/Therapy:		Provider:
Dates of Service:		Address:
Phone:	May we contact:	Hours per week:
Service/Therapy:		Provider:
Dates of Service:		Address:
Phone:	May we contact:	Hours per week:
Service/Therapy:		Provider:
Dates of service:		Address:
Phone:	May we contact:	Hours per week:

Behaviors of Concern

ISSUE	√ or X	COMMENTS
Self-stimulatory behaviors: vocal, flapping, lining up objects		
Self-injurious behaviors: banging head, eye poking, biting self		
Unsafe behaviors to self: running away, climbing on furniture		
Unsafe behaviors to others: hitting, throwing, objects		
Ritualistic/obsessive behaviors: wearing same clothes, only talks about one topic		

Concerns with accepting no/ transition		

Please provide more details concerning challenging behaviors using the chart below.

Behavior	How often does it happen? DAILY WEEKLY MONTHLY SEVERAL TIMES A YEAR	How long does it usually last? SECONDS 1-5 MIN 5-15 MIN < 30 MIN	What kind of damage does it cause?	What could you do that would guarantee I would see the behavior?	What could you do that would very likely make the behavior stop?
1.					
2.					
3.					
4.					
5.					

Please list any fears or non-preferred items/activities your child may have:

Please list any reinforcers your child may have:

Extra-Curricular Activities

Please indicate any extra-curricular activities, including sports, clubs, hobbies, lessons, etc.:

Football	**Karate**	**Dance (Type)**
Baseball	Piano	Music (Type)
Cheerleading	Scouts	Gymnastics
Basketball	Soccer	Other:

Any other information that may be useful

Additional Client Resources

The NC Department of Health and Human Services
Mailing address: 2001 Mail Service Center
Raleigh, NC 27699-2000
For COVID-19 questions call 2-1-1 or 888-892-1162

Division of Health Services Regulation's Complaint Intake Unit
1-800-624-3004 (within N.C.) or 919-855-4500

Reporting and Documentation of Suspected Abuse, Neglect, & Exploitation
Employees of Innovative Care Network are notified upon their employment that they are required by law to report suspected abuse to their manager and/or appropriate state or local authorities. All clinical records will contain proper documentation pertaining to suspected abuse. Please refer to Job Description Documents for details on how to report abuse. All cases will be reported/debriefed to the Director of ABA Services and documented in the patient/client file.

Referral Resources
Assessments and referrals for ABA therapy can be obtained by an appropriate provider type including: psychiatrist, developmental pediatricians, pediatric neurologists, and psychologists trained in the diagnosis of Autism Spectrum Disorders. The NC Department of Health and Human Services has a comprehensive list of Centers of Excellence for Autism and licensed providers of ABA and Behavior intervention providers.