Dear Caregiver:

Thank you for your interest in Central Mass Clinical Associates (CMCA) to help meet the needs of your child. We know you have many options to choose from and appreciate you having selected us to assist you with this important process.

Please complete the attached intake forms to provide CMCA with information to assess how we can be of service. Once the intake forms have been completed, they will need to be returned to CMCA with the following documents to be considered for services.

- Current IEP or 504 plan (if applicable)
- Updated Neuropsychological Evaluation (3 years or newer)
- Updated Physical Evaluation (within 1 year)
- Copy of Insurance cards (front and back)

All forms and documents can be returned by the following methods.

- Email: intakes@centralmassca.com or wmankowska@centralmassca.com
- Fax: 1-508-409-6366
- Mail: Central Mass Clinical Associates
  108 Grove St Suite 205, Worcester MA 01605

Thank you again for your interest in our services and we look forward to meeting you and your family.

Sincerely,

Kristi Lombardo

Kristi Lombardo, M.S.Ed, BCBA, LABA
President, Clinical Services

CMCA
Central Mass Clinical Associates

NEW CLIENT INTAKE

DATE_____

Client Information

Client Name: _____ Date of Birth: ____/ ____/ ____ Age: ____

Gender: _____ Address: _____

City/ Town: _____ Zip Code: _____

Current School attending and grade _____

Is he or she on an IEP or 504? Please circle one : IEP/504

Caregiver Information:

Caregiver Name: _____ Date of Birth: ____/ ____/ ____

Relationship: _____ Address:_____

City/ Town: _____ Zip Code: _____

Home Phone: _____ Email: _____

Employer: _____Occupation: _____

Work Phone: _____ Email: _____

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Additional Caregiver Information

Caregiver Name: _____ Date of Birth: ____/ ____/ ____

Relationship: _____ Address: _____

City/ Town: _____ Zip Code: _____

Home Phone: _____ Email: _____

Employer: _____Occupation: _____

Work Phone: _____ Email: _____

Siblings/Household Members (Other than Caregiver)

Name: _____ Relationship: _____

Date of Birth: _____/_____/_____Age: _____

Name: _____ Relationship:

_____ Date of Birth: _____

Age:_____

Name: _____ Relationship:

_____ Date of Birth: _____

Age:_____

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Additional Information

What behaviors is your child exhibiting?

_____
_____
_____
_____
_____

What are your goals for your child?

_____
_____
_____
_____
_____

Who is your child's Primary Care Physician?

_____

Contact Info:

_____
_____
_____

Does your child take any medications? Yes/No

If yes, please list the medications:

_____
_____
_____
_____

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Emergency Contact Information

Name: _____

Phone Number: _____

Relationship to Child: _____

Name: _____

Phone Number:_____

Relationship to Child: _____

Name: _____

Phone Number:_____

Relationship to Child: _____

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Insurance Information:

Primary Insurance:

Insurance Carrier: _____

Policy Number: _____

GroupNumber: _____

Policy Holder Name: _____

Secondary Insurance:

Insurance Carrier: _____

Policy Number: _____

GroupNumber: _____

Policy Holder Name: _____

***** Central Mass Clinical Associates will need a copy of all insurance cards****

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Schedule

ABA SERVICES:

Please complete the following schedule blocks for when your family would be available to receive ABA services.

****** Please keep in mind that someone 18 or older must be present while ABA services are being provided******

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
Midday							
PM							

CAREGIVER/ FAMILY TRAINING:

Caregiver/ Family training provides an opportunity for a Board-Certified Behavior Analyst to meet with a family or caregiver without the child being present. This training focuses on teaching family members or caregivers' techniques to use when engaging with their child. Please complete the following schedule blocks for when a caregiver or family would be available for training.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
Midday							
PM							

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Health Insurance Portability and Accountability Act

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

_____

Caregiver Signature

CMCA
Central Mass Clinical Associates

Patient's Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting 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 you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints made about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in one set of professional records. The Clinical Record includes information about reasons for seeking our professional services; the impact of any current or ongoing problems or concerns; assessment, consultative, or therapeutic goals; progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Personal notes are taken during supervision sessions by the Behavior Technician. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms described above.

_____
Client's Name

_____
Caregiver Printed Name

_____
Caregiver Signature

_____
Date

Consent to Collaborate

I, _____, ***GIVE*** permission to Central Mass Clinical
Guardians Name

Associates (CMCA) to collaborate on my child's, _____ behalf with the following:
Child's Name

School: _____

Doctor: _____

Speech Therapist: _____

OT Therapist: _____

Other: _____

_____

_____

I, _____, ***DO NOT GIVE*** permission Central
Mass Guardians Name

Clinical Associates (CMCA) to collaborate with any other providers at any time.

_____ _____ Printed Name
of Guardian Relationship

_____ _____Signature of
Guardian Date

Consent to Treatment

I, _____, ***GIVE*** permission to Central Mass Clinical
Guardians Name

Associates (CMCA) to provide ABA treatment to my child, _____.
Child's Name

I understand that these services will include Caregiver/ Family Training, Direct 1:1 therapy provided by a Behavior Technician (BT), Registered Behavior Technician (RBT) or by a Licensed Applied Behavior Analyst (LABA)/ Board Certified Behavior Analyst to work with my child, and oversight of programming and supervision of a BT or RBT provided by a BCBA/LABA. Other services that will be conducted by a BCBA/LABA are assessments, caregiver interviews and direct observations of the child. CMCA will also collaborate with other care providers, schools, and doctors to provide complete wrap-around service for the family. I also understand that these services will take place in multiple settings. These settings include but are not limited to:

- In-Home Therapy
- Community-Based Therapy
- Social Skills Groups
- Day-Cares
- After-School Activities

I, _____, ***DO NOT GIVE*** permission Central
Mass Guardians Name

Clinical Associates (CMCA) to provide ABA treatment to my child

_____ _____ Printed Name
of Guardian Relationship

_____ _____Signature of
Guardian Date

CMCA
Central Mass Clinical Associates

CHECKLIST

Please use this checklist to ensure that you are returning the intake packet with all documents required. Without the appropriate documents we can not move forward with ABA services through the insurance company.

- ☐ Completed all pages of Intake Packet
- ☐ Have included a copy of an IEP or 508 (if applicable)
- ☐ Have included a copy of your child's latest Physical
- ☐ A copy of your child's Neuropsychological Evaluation
- ☐ A copy of your child's insurance card (front and back)