A-2-Z Therapy
Guiding Potential, Reaching New Heights

CLIENT INTAKE FORM

CLIENT INFORMATION:

Date: / /

Client Name:		
D.O.B:	Age:	SSN:
Race:	Gender:	
Address:	Phone Number:	

EMERGENCY INFORMATION:

Parent/Guardian Contact Information:

Name:	Relationship:
Address:	Phone Number:

Secondary Person to contact in case of an emergency:

Name:	Relationship:
Address:	Phone Number:

Primary Physician Name & Facility:	
Phone Number:	Fax:

Any Allergies:

Other medical conditions:

Informed Consent For
APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES

CLIENT INFORMATION:

Client Name:	D.O.B:
Parent/Guardian Name:	

1. PURPOSE AND SCOPE OF ABA SERVICES

Applied Behavior Analysis (ABA) is an evidence-based approach designed to increase positive behaviors, reduce challenging behaviors, and teach new skills. ABA services are customized to meet the unique needs of each client and may include:

a. Assessment of current skills and behaviors.
b. Development of an individualized treatment plan.
c. Implementation of evidence-based interventions.
d. Ongoing progress monitoring and adjustments to the treatment plan.

2. NATURE OF ABA SERVICES

ABA services may involve:

a. One-on-one therapy sessions.
b. Group interventions, as appropriate.
c. Parent/caregiver training to support skill generalization.
d. Use of reinforcement and other behavior modification strategies.
e. Data collection for decision-making and treatment evaluation.

3. POTENTIAL BENEFITS AND RISKS

Benefits:

a. Improved communication, social, academic, and daily living skills.
b. Reduction in problem behaviors.
c. Increased independence.

Potential Risks:

a. Temporary increases in challenging behaviors during the initial stages of intervention.
b. Emotional discomfort during new or difficult tasks.
c. Variability in outcomes depending on client engagement and consistency of implementation.

4. RIGHTS OF THE CLIENT AND FAMILY

a. You have the right to ask questions about your treatment plan and interventions.
b. You can withdraw consent for services at any time without penalty.
c. You will receive regular updates on your or your child's progress.
d. Confidentiality will be maintained according to HIPAA regulations, except in cases required by law (e.g., safety concerns, abuse reporting).

5. RESPONSIBILITIES OF THE CLIENT AND FAMILY

a. Provide accurate and complete information about the client's needs, history, and preferences.
b. Actively participate in treatment by implementing recommendations and attending parent training sessions.
c. Maintain consistency with strategies outside of therapy sessions.
d. Notify the provider of any changes in circumstances or concerns about treatment.

6. CONFIDENTIALITY AND DATA USE

All client information will remain confidential and be used only for treatment, billing, or research purposes (with additional consent). Exceptions include:

a. Threats of harm to self or others.
b. Suspected abuse or neglect.
c. Legal obligations, such as court orders.

7. EMERGENCY AND CRISIS SITUATIONS

ABA providers are not crisis intervention specialists. In case of an emergency, call 911 or your local emergency services.

8. CONSENT FOR SERVICES

By signing below, I confirm that:

a. I have read and understood the purpose, nature, and risks of ABA services.
b. I have had the opportunity to ask questions, and my questions have been answered.
c. I voluntarily give my informed consent to receive ABA services for myself/my child.

Client/Parent/Guardian Signature: _____ **Date:** _____

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EMERGENCY FACT SHEET

CLIENT INFORMATION:

Client Name:	D.O.B:
Parent/Guardian Name:	

INSURANCE INFORMATION:

Primary Insurance Type and Number#:
Secondary Insurance:
Allergies:

List any conditions and medications and name of physician below:

Medical Condition	*Attending Physician*	*Phone Number*	*Prescribed Medication*	*Dosage*

Sex:	Race:	Height:	Weight:
Eye Color:		Hair Color:	
Other Identifying Marks:			
Address:		Phone Number:	

Person to be Contacted in case of an Emergency (not parent/guardian):

Name:	Phone Number:
Preferred Physician:	Phone Number:

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INFORMING OF RIGHTS AND RULES

CLIENT INFORMATION:

Client Name:	D.O.B:
Parent/Guardian Name:	

The consumer and legally responsible person should initial each item.

☐ I have received the policies and procedures for:

a. The rules to follow, including the possible penalties
b. My protection regarding confidential information, and disclosure of such;
c. How to receive a copy of my service plan;
d. Fees charged, and collection of those fees for treatment provided;
e. Grievance procedure to follow;
f. Suspension and expulsion from services;
g. Search and seizure of persona

☐ I understand I can contact the Protection and Advocacy for People with Disabilities.

☐ I understand the benefits, potential risks, and possible alternative methods of treatment.

☐ I understand I have the right to refuse treatment at any time but choose to consent to treatment at this time. I further understand my refusal will not be used as sole grounds for termination of services unless the treatment is the only viable option available at Aspire Behavioral Center.

☐ I understand I have the right to be free from harm, abuse, neglect and exploitation.

☐ I have received a copy of the consent handbook, and related application information.

I certify the above information is current and has been explained to me so that I may understand it. I certify the opportunity to ask questions and had them all answered. I further acknowledge receipt of the about information in writing, upon my admission file.

Client or Legal Guardian Signature: _____ **Date:** _____

(if applicable)

Staff Signature: _____ **Date:** _____

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CONSENT TO SEEK EMERGENCY CARE

CLIENT INFORMATION:

Client Name:	D.O.B:
Parent/Guardian Name:	

Legal Guardian (if jointly assigned, all parties must sign):

I give permission for to seek emergency care for _____ from the closest medical care provider available. In case of an extreme emergency, and I cannot be contacted, I give the attending physician permission to provide sufficient care that is needed until I can be reached.

Consumer/Legally Responsible Person: _____ **Date:** _____

Witness: _____ **Date:** _____