Social Connections Learning Center-Katy, LLC
1850 Avenue D Suite #100
Katy Texas 77493

Parent Initials _______ SUP Initials________

CLIENT INFORMATION:

Name: ____

Date of Birth:________________________________ **Gender:**___________________________

Address:____

City:______________________________**State:**_______________________**Zip:**_____________

Parent/Guardian:____

Home Phone Number: ____

Diagnosis:

SCHEDULE AVAILABILITY

Please list all times your child is available for therapy between the hours of 8:00 and 5:30pm M-F:

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 Insurance Portability and Accountability Act (HIPAA), a new 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. Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. e law requires that we obtain your signature acknowledging that we have provided you with this 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 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. 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 seeking appropriate hospitalization.

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INFORMED CONSENT AGREEMENT

I consent and agree to have my child assessed and/or treated by Social Connections Learning Center-Katy, LLC. I understand that the therapy provided by Social Connections Learning Center-Katy, LLC is Applied Behavior Analysis (ABA) and that services will be provided by staff members who have been trained in ABA.

I have reviewed and received copies of the Social Connections Learning Center-Katy, LLC. "Notice of Privacy Practices" and "Patient Rights and Responsibilities" documents. I also understand my payment obligations in accordance with my insurance company's policies or my agreement with Social Connections Learning Center-Katy, LLC., whichever is applicable.

Questions, concerns, or complaints may be directed to Brittany Hillhouse, Director of Programs, Bhillhouse@sclckaty.com , (281) 799-1744

____ ________________________________

Signature **Date**

____

Printed Name

PROFESSIONAL CONSULTATIONS

If you want us to talk with or release specific information to other professionals with whom you are working, you will be required to sign an Authorization form that specifies what information can be released and with whom it can be shared.

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FINANCIAL INFORMATION

We are always open to learning about your coverage or changes in practices and policies of insurers. We are currently accepting payment for services through Aetna, Blue Cross Blue Shield, Cigna, Humana, and private pay.

It is our policy to invoice families for cost-share weekly. Payment is due by the date of the invoice by deduction from the credit card we have on file on the credit card authorization form. There is a $70 Returned Check fee for all checks returned by the bank. ________**Initial**

If we bill your insurance claims, you are responsible for co-payment and additional fees not covered by insurance. By initialing, you are acknowledging that you understand this condition of service and commit to promptly paying Social Connections Learning Center-Katy, LLC for the services we provide to you. We accept credit card deductions only for services, these payments are due the week of, typically the Friday after therapy is provided. If your healthcare insurance payer does not cover ABA therapy services, you are required to make self-pay arrangements for the usual and customary pricing of our services (see self-pay rates below). ________**Initial**

Social Connections Learning Center-Katy, LLC
1850 Avenue D Suite #100
Katy, TX 77493
Ph. (281) 799-1744
Website: www.sclckaty.com

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Client Financial Responsibility

Client Name: ___________________________________ Date: ____________________

Social Connections Learning Center-Katy, LLC, requires this form to be completed by all clients. We appreciate your cooperation, and if you have **ANY** questions please ask.

1. **Financial Responsibility:** I understand that Social Connections Learning Center-Katy, LLC will make all reasonable attempts to bill my insurance company first, and will work with me to address potential problems. However, in the event that my insurance company does not pay for any portion of services provided, I agree and acknowledge that I am responsible for any fees remaining.

Signature of Client or Legal Guardian: ____

2. **Authorization to Release Information:** I authorize Social Connection Learning Center-Katy, LLC, to release information requested by my insurance company to complete my claim.

Signature of Client or Legal Guardian: ____

3. **Authorization to Pay Claims to Social Connections Learning Center-Katy, LLC:** I authorize payment from the insurance company to be directly sent to Social Connections Learning Center-Katy, LLC. This allows Social Connections Learning Center-Katy, LLC to file claims on my behalf.

Signature of Insured: ____

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Assignment of Benefits

Financial Responsibility

I have requested Applied Behavior Analysis (ABA) therapy services, or any of the services as indicated below, on behalf of myself and/or my dependent(s) from Social Connections Learning Center-Katy, LLC (SCLC) and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that deductibles and co-payments are due and payable on the date that services are rendered and agree to pay all such charges incurred, in full, immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private health insurance and any other health/medical plan, to issue payment check(s) directly to SCLC, LLC for medical services rendered to me or my dependents, regardless of my insurance benefits, if any. I understand if my benefits are not able to be verified, payment will be due at the time of service. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize SCLC, LLC to: (1) release any information necessary to insurance carriers regarding me or my dependent's illness and treatment; (2) process insurance claims generated in the course of assessment or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me and writing.

I have read and agree to the terms outlined above.

____ ________________________

Patient/Responsible Party Signature Date

____

Printed name

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Credit Card Authorization Letter

I consent and authorize the use of my credit card as described below for charges related to services provided by **Social Connections Learning Center-Katy, LLC.**
(Please print legibly)

Name on Credit Card: ____

Credit Card Type: VISA MASTERCARD DISCOVER

Credit Card Number: ____

Expiration Date: ____

Security Code: ____

Billing Address: ____

____

Telephone Number: ____

Cardholder Signature: ____

Date: ____

____ **Initial** I understand that my credit card will be billed at the end of the week in which therapy services were rendered.

____ **Initial** I understand that my credit card will be billed $100.00 every day for sessions canceled with less than a 24-hour notice.

____ **Initial** I understand that in the event that my credit card is declined, there will be a $70.00 penalty fee added to my bill and my credit card will be billed until payment is received for outstanding invoices.

____ **Initial** I understand that my credit card will be billed for additional fees, such as late arrivals and late pick-ups. See cancellation policy for these fee rates.

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CONTACTING US

Given our staff's professional commitments, our clinical staff 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 a message with some dates/times when you will be available. We do not provide on-call coverage.

Please contact schedule@sclckaty.com for any scheduling concerns, questions or cancellations.

Contact bhillhouse@sclckaty.com for any insurance and treatment questions.

In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

CANCELLATION POLICY

We appreciate the opportunity of being of service to you. Our office is dedicated to excellence in patient care. Please take a moment to read and become familiar with this policy. Should you have any questions, the office staff is happy to help. By presenting this policy in advance, we can avoid any surprises or misunderstandings. We appreciate your time and understanding.

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please email schedule changes to schedule@katysclc.com. We understand occasional changes are necessary due to illness, vacations, etc. Please email and call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday morning appointments, our office appreciates being notified no later than Friday noontime. This will allow other patients in need of care to be accommodated as we have a waiting list. It is both unfair to the other patients and therapists to not allow for others to schedule in the open time slots.

If a session is more than 5 minutes delayed due to late arrival of the client, the parent(s)/guardian will be charged a $1.00/minute late fee. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian. _____ **Initial**

If a parent(s)/guardian is more than 5 minutes late to pick their child up, the parent(s)/guardian will be charged $1 for every minute past the therapy scheduled time. It is to ensure that parents are present so the therapist can accommodate other clients' needs as scheduled. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian. _____ **Initial**

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In the event that a therapy session is canceled within 24 hours of the appointment time or is missed without any notice (this is counted as a no-show - except in cases of emergency), it will result in a cancellation or no-show fee of $100. **Note: Insurance companies DO NOT reimburse for no show fees; this is the responsibility of the parent(s)/guardian. _____ **Initial**

We request that families give us at least four weeks' notice on significant changes in their plans for ABA therapy sessions scheduling in order to facilitate consistency in service delivery. _____ **Initial**

Two consecutive no-shows require your child to be placed on an on-hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, your child will lose his/her therapy time and be placed on a waiting list. _____ **Initial**

We require that clients receive services for 80% of their recommended treatment hours as specified in the treatment plan. This is to ensure that treatment is consistent and application of interventions are successful. Note: We will be tracking visit numbers and as a courtesy, we will notify you when your percentage drops below the required 80%. _____ **Initial**

The universal standard for therapy, be it the insurance standards or the professional standards of various organizations like the APA, ASHA, etc., is that a therapy: "hour" is 45-50 minutes of direct contact with the patient with the remaining 10-15 minutes devoted to required record keeping and other administrative requirements. During this time therapy is structured to target the client's independent tasks as developed in the treatment plan. Typically, for a 4-hour in-home therapy session, our staff take ~10 minutes to arrange the materials prior to commencing direct therapy with the child and ~ 15 minutes at the end to record data, tidy the setting, and render services. _____ **Initial**

We are happy to accommodate your scheduling needs. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, such as an extended trip, we will hold your therapy spot for up to two weeks. After two weeks, we will be required to place you on the waiting list, and will contact you when we have availability. _____ **Initial**

I hereby understand the above cancellation policy and agree to abide by it.

Parent or Legal Guardian Signature: ____ **Date:**________________

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Notice of Privacy Practices

THIS NOTICE DESCRIBES OUR MEDICAL INFORMATION ABOUT YOU AND HOW IT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected Health Information (PHI) is information, including demographic information, that is created or received by The Social Connections Learning Center-Katy, LLC, identifies an individual or there is a reasonable bias to believe it could be used to identify an individual, and relates to the past, present, or future physical or mental health or condition of the individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. We are required by law to maintain the privacy of PHI and to provide individuals with notice of our legal duties and privacy practices with respect to PHI.

The Social Connections Learning Center-Katy, LLC reserves the right to change this privacy notice and to make the revised notice provisions effective for all PHI that we maintain. We will provide any revised notices to you on or before the effective date of the revisions.

<u>Your Protected Health Information Rights & Responsibilities</u>

<u>You have the right:</u>

To request that your Private Health Information be restricted from disclosure for purposes of treatment, payment, or health care operations. You may also request that your healthcare information be restricted from disclosure to family, relatives, friends, and any other individuals.

The Social Connections Learning Center-Katy, LLC is not required to agree to your requested restrictions. If we do agree to the restrictions, we will not disclose your PHI unless it is required to be disclosed by law or for emergency purposes.

<u>To request communication of PHI alternative means or alternative locations</u>

Requests for alternative means and locations of communication must be made in writing to our privacy officer.

To inspect and copy PHI about the individual in a designated record set, for as long as that information is maintained in the designated record set. Information that may be excluded from the designated record set are notes that may be compiled in anticipation of a civil, criminal, or administrative proceeding, or notes that may have been obtained from someone else under a promise of confidentiality.

<u>To amend PHI in a designated record set, for as long as the protected information is maintained in the designated record set</u>

We may deny the request for the amendment if we determine that the information was not created by us, is not part of the designated record set, or is accurate and complete.

To request an accounting of PHI disclosures in the six years prior to the date of the request for accounting, except for disclosures made for purpose of carrying out treatment, payment, and healthcare operations; disclosures made to the individual; disclosures made with authorization; or disclosures made for emergency purposes.

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Disclosures That May Be Made Without Your Authorization
We may disclose PHI as required by law. We may also disclose individual protected health information: 1.) to the individual, the parents, or legal guardians and; 2.) for treatment, payment, or health care operations.

Treatment- Disclosure of PHI for treatment includes but is not limited to disclosure to the staff working with the individual, consultants who provide advice to us regarding treatment of the individual, and other staff members who may provide periodic support to the staff working with the individual.
Payment- Disclosure of PHI for payment purposes may include but is not limited to disclosure for purposes of determining eligibility or coverage, authorization for services, and billing and claims management.
Healthcare Operations- Disclosure for healthcare operations may include but not be limited to employee training, business management, and administration practices.

Other disclosures of PHI which may be made without specific authorization from the individual include the following:

- To a public health authority that is authorized to collect the information for a purpose of preventing or controlling disease, injury, or disability;
- To a public health authority or other government authority authorized by law to receive reports of child abuse, neglect, or domestic violence;
- To a person subject to the jurisdiction of the Food and Drug Administration (FDA) to report adverse events, track products, enable product recalls, or conduct post marketing surveys;
- To a person, or parent or guardian of a person, who may have been exposed to a communicable disease or may be at risk for contracting the disease or condition;
- To an employer, regarding an employee who is covered by health care benefits through employment, by the health care provider, for purposes of medical surveillance of the workplace or for evaluation of whether or not the individual has a work-related injury.
- To a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, civil, administrative or criminal proceedings or actions, or other appropriate activities necessary for oversight;
- In response to an order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful purpose;
- To a law enforcement official for a law enforcement purpose;
- To a coroner, medical examiner, or funeral director for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law;
- To organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation and transplantation;
- For research, provided that the disclosure has been approved by the institutional review board or privacy board;
- If we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
- For individuals who are military personnel for activities deemed necessary by appropriate military command authorities; and
- To comply with workers' compensation laws or other similar programs.

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Disclosures That May Be Made Unless You Object

The following disclosures of PHI may be made with your verbal approval and may not be made if you verbally object to the disclosures:

1.) to a family member, other relative, close personal friend of the clients' family, or any other person identified by the clients' family, the PHI directly relevant to the person's involvement with the clients' care or payment related to the clients' care; and
2.) to the public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Disclosures That Require Your Authorization

The following disclosures of PHI require your authorization:

1.) the disclosure of therapy notes, except: for purposes of carrying out treatment, payment, or health care operations; for use by the originator of the notes for treatment, use or disclosure for training purposes, or for use by The Social Connections Learning Center-Katy, LLC to defend ourselves in a legal action or other proceeding brought by the client or their families.
2.) For marketing purposes, except if the marketing is the form of face-to-face communication made to an individual.

Complaints

If you believe that your privacy rights have been violated, you may contact or file a complaint with our Privacy Officer, Brittany J. Hillhouse, at bhillhouse@sclckaty.com or (281) 799-1744, or
The Social Connections Learning Center-Katy, LLC,
1850 Avenue D Suite #100
Katy, TX 77493
You will not be retaliated against for filing a complaint.

You may also file a complaint with:
Office of Civil Rights
U.S Department of Health and Human Services
1302 Young Street
Suite 1169
Dallas, TX 75202
Voice Phone: (214) 747-4056
Fax: (214) 767-0432
TDD: (214) 767-8940

For Your Protection	THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Privacy of Your Health Records	We understand that information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information

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	and following all laws about its use. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says: 1. We must keep your health care information from others who do not need it. 2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request: (a court order would be an example of one of these situations).
Who will see your protected information	The agreement you sign with us may cover health care services you had before now or may have later. We review your health care information and submit claims to payers you have agreements with to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives. We may share your health care information with health plans, insurance companies, and government programs to help you get your benefits, and so we can be paid for your health care services.
Your Access to Protected Health Records	In almost all cases, you may see your health care information. You may ask in writing to receive a copy of your health care information. If you think some of your health care information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your health care information from us. Note: If you are younger than 18 years old and, by law, you are able to give consent for your own health care, then your health care information is kept private from others unless you sign an authorization form.
Others we may share your information with	We follow the law which tells us when we ARE REQUIRED to share health care information, even if you do not sign an authorization form. We may be required to report: 1. contagious diseases, birth defects and cancer; 2. injuries and other trauma events; 3. reactions to problems with medicines or defective medical equipment; 4. to the police when required by law; 5. when the court orders us to; 6. to the government to review how our programs are working; 7. to an insurance company who needs to know if you received services from us;

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	8. to Workers Compensation for work related injuries; 9. birth, death and immunization information; 10. to the federal government during the course of an investigation; 11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults. We may also share health care information for government permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.
Your Right to this Notice	This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days if you are currently receiving services.

Permission to Photograph

I give permission and consent for Social Connections Learning Center-Katy, LLC to photograph my child and/or myself during the time my child is receiving services. I understand these photographs may be used in educational training presentations.

Child's name: ____ **Date of birth:** ________________________

Print name (parent/guardian): ____

Signature (parent/guardian): ____ **Date:** _______________

PERMISSION TO VIDEOTAPE OR AUDIOTAPE

I give permission and consent for Social Connections Learning Center-Katy, LLC to videotape and/or audio tape my child and/or myself during the time my child is receiving therapy services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Social Connections Learning Center-Katy, LLC and the family.

Child's name: ____ **Date of birth:** ________________________

Print name (parent/guardian): ____

Signature (parent/guardian): ____ **Date:** _______________

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In addition to the above, I also give permission for Social Connections Learning Center-Katy, LLC to use recorded video segments to present to parents and professionals for conferences and/or other training purposes.

_____________________________ _____________________________ _______________

Print name (parent/guardian) **Signature (parent/guardian)** **Date**

PERMISSION TO CONDUCT BODY CHECKS

I give consent to Social Connections staff to conduct physical body checks at arrival and dismissal while receiving therapy services. The body check includes reporting any observation of marks and/or bruises that are observed on the physical body. The procedure will include removing the client's shirt and skimming legs and thighs for inconsistencies.

Child's name: ____ **Date of birth:** ________________________

Print name (parent/guardian): ____

Signature (parent/guardian): ____ **Date:** _______________

RELEASE OF PATIENT INFORMATION AUTHORIZATION FORM

PATIENT NAME:	**SSN:**
DATE OF BIRTH:	**Nicknames:**

PEOPLE & ENTITIES I AUTHORIZE TO RECEIVE MY PROTECTED HEALTH INFORMATION:

NAME OF ENTITY	**CONTACT INFORMATION**

Please list medical practitioner(s), spouse, caregiver(s), guardians(s), etc. you are authorizing to receive PHI.

The purpose of this release of protected health information authorization:

I hereby authorize the use or disclosure of my health care and/or other information within my patient record to the entities stated above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand that I may revoke this authorization at any time by signing the

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revocation section at the bottom of this form, or by notifying Social Connections Learning Center-Katy, LLC in writing, but if I do, it will not affect actions taken on this authorization before my revocation was received. I understand that Social Connections Learning Center-Katy, LLC, LLC will not condition my treatment, payment, or eligibility for services based on whether I provide this authorization.

I understand that if the person(s) or entities I authorize to receive my protected health information are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulation. To the extent that this information is required to remain confidential by federal or state law, the recipients of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event:
Signature of Patient or Personal Representative: Date: (Or Witness if signature is by mark)
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:
NOTE: is authorization was revoked on: __________ (see attached revocation), Complete when/if revoked. **Date: ___________**

A PHOTOCOPY OF THIS AUTHORIZATIONS IS AS VALID AS THE ORIGINAL

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SOCIAL CONNECTIONS HIPAA CONFIDENTIALITY & RELEASE FORM

CLINIC TOURS & PARENT TRAINING VISITS, INCLUDING OBSERVATIONS

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Social Connections Learning Center-Katy, LLC (SCLC) has a legal and ethical responsibility to take certain administrative safeguards that protect the privacy of all SCLC clients and that protect the confidentiality of their health information.

In the course of your tour / visit, you may hear, read or see information that relates to a patient's health either in electronic form or paper files containing Protected Health Information (PHI). Because you may read, see or hear PHI, SCLC requests that you agree to the following as a condition of your tour / visit:

Confidential / PHI:

I understand that all health information that may in any way identify a patient or relate to a patient's behavioral health must be maintained confidentially. I will regard confidentiality during my tour / visit.

Prohibited Use and Disclosure:

I agree that I will not reveal to anyone the names of the individual clients whose care and treatment I observe as a result of my participation in the tour /visit, nor will I discuss with anyone any details that might cause any patient's identity to be revealed.

I do hereby agree to assume the entire risks attendant to such activity as my tour / visit, I do hereby release and forever discharge the behavioral health clinic, their employees, agents, leases, contractors, and concessionaires, in both their public and private capacities on and from any and all liability, claims, suits, damage, or causes of action whatsoever for any property damage or personal injury sustained or that may arise in any manner in connection with taking part in the tour / visit. I will assume all responsibilities related to accidents or other difficulties.

By my signature below, I have read this Confidentiality and Release of Liability form, and fully understand these terms and conditions, and further understand that the opportunity to participate is based on the signing of this document.

Signature ____ Date ____________________

Print Name ____

Parent/Legal Guardian if Participant is under 18 ____

Date _________________________

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Social Connections Learning Center-Katy, LLC

Authorized Release of Client Form

I consent to authorize Social Connections Learning Center-Katy, LLC (SCLC) to release my child from the Social Connections Learning Center-Katy LLC (SCLC), at any time, to the following authorized person(s).

______________________________ ______________________ ____________________
Name of person Relationship Texas DL #

______________________________ ______________________ ____________________
Name of person Relationship Texas DL #

______________________________ ______________________ ____________________
Name of person Relationship Texas DL #

______________________________ ______________________ ____________________
Name of person Relationship Texas DL #

By signing this form, I understand that I am authorizing the Social Connections Learning Center-Katy LLC, to release my child to this person(s) and it is my responsibility to remove and notify the SCLC immediately in the event that a person should need to be removed. I also understand that Parent 1 holds the authority to make such decisions as adding and removing authorized person(s) for the release of my child.

____ ___________________________________
Parent Signature Date

CONSENT FOR RECEIVING THE PARENT HANDBOOK

I have received a copy and understand the information in the parent handbook and agree to the terms and policies set forth by Social Connections Learning Center-Katy, LLC.
Signature ____ Date ___________________
Print Name ____

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New Client Intake Information

This information will become part of the patient's permanent record and is confidential. Please ensure the information provided is accurate.

PATIENT INFORMATION

Child's name: ___________________________________ DOB: _____________ Age: ______
Gender: ☐M ☐ F
Primary Diagnosis: ____
Additional Diagnoses: ____
Age of Diagnosis: _____ By Whom: ___________________________
Location: ___________________________
Mother's name: _________________________ DOB: ____________
Phone: _________________________ Email: _________________________
Employed: ☐Y ☐N
Employer: ____
Father's name: _________________________ DOB: ____________
Phone: _________________________ Email: _________________________
Employed: ☐Y ☐N
Employer: ____
Additional Caregivers: ____
Sibling(s) (name/age): ____

SCHOOL INFORMATION

Has your child been evaluated through public school? Yes or No
If yes, please answer the following:
School District:_______________________________ Name of School:___________________________________
Grade Classification:___________ Program Placement:________________________(self-contained, gen. ed etc.)
Please submit all ARD or special education paperwork, past and concurrent for BCBA review. All paperwork must be shared, and any new information or documentation must be submitted to the BCBA upon agreement by the parent/guardian to ensure treatment is being targeted as recommended by the BCBA.

EMERGENCY CONTACT

Name: _________________________ Relationship: _____________
Phone: _______________________ Email: _________________________
Name: _________________________ Relationship: _____________
Phone: _______________________ Email: _________________________

MEDICAL INFORMATION

Primary Care Physician: ___________________________________
Primary Care Hospital: _____________________________________
Phone: ______________________________
Allergies: ☐Y ☐N
Type/Severity: ____
Dietary Restrictions: ____

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Katy Texas 77493

Parent Initials _______ SUP Initials________

PRIMARY CONCERN/REASON FOR TREATMENT

____

____

____

New Client Intake Form

This information will become part of the patient's permanent record and is confidential. Please ensure the information provided is accurate.

PERINATAL HISTORY

Age weeks/gestation: _______ Birth Weight: ____________

Pregnancy complications: ____

____

Delivery: ☐Vaginal ☐Induced C-section ☐

Complicated Delivery: _______________________________________

Complications after delivery:

____

____

DEVELOPMENTAL HISTORY

Handedness: ☐Left ☐Right

New Client Intake Form

PAST MEDICAL HISTORY

Please describe any past medical conditions your child may have had.

Where possible, give dates of illnesses/surgeries.

Major illnesses requiring hospitalization or ER visit:

____

Surgeries: ____

____

Other known medical conditions not listed above:

____

PAST FAMILY MEDICAL HISTORY

Please describe any medical conditions that exist or have existed in close family members. List the problem and affected individual(s) if known.

____

____

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SOCIAL HISTORY

Who currently resides in your child's home?

____

____

Are there any factors related to custody? Please explain:

____

Please list your child's school, hours of attendance, and current grade:

____

____

If your child attends day-care, please list number of days/week:

____

Is there any known history of alcohol, tobacco, or drug abuse?

Yes ________ No ________

Is there any litigation pending on your child's medical condition?

Yes ________ No ________

<u>New Client Intake Form</u>

REVIEW OF SYSTEMS

Please indicate if your child has ever had any medical problems in the following areas, within the past month.

GENERAL

☐ Fever: how many days___ how high_____ did temperature return to normal without medication? Y ☐ N ☐

☐ Fatigue ☐ Recent weight loss or gain ☐ Heat or cold intolerance ☐ Difficulty sleeping

GENITOURINARY

☐ Pain with urination ☐ Increase in frequency/urgency ☐ Blood in urine

FEMALES ONLY

☐ Menstrual cycles, started at age _____

☐ Headaches ☐ Loss of hair ☐ Swollen glands ☐ Date of last eye exam _________ ☐ Red or irritated eyes

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Parent Initials _______ SUP Initials________
☐ Hearing difficulties ☐ Mouth sores ☐ Sore throat

CARDIOVASCULAR
☐ Irregular heartbeat ☐ Murmur ☐ Palpitations

GASTROINTESTINAL
☐ Loss of appetite ☐ Difficulty swallowing/feeling of food getting stuck ☐ Nausea
☐ Vomiting ☐ Pain or cramps in abdomen ☐ Diarrhea ☐ Constipation
☐ Allergy: ________________

NERVOUS SYSTEM
☐ Seizures ☐ Decreased sensation ☐ Abnormal gait

SKIN
☐ Rash over cheeks ☐ Hives or welts ☐ Easy bruising ☐ Skin tightening or hardening
☐ White, blue or red skin color change in fingers with exposure to cold or emotional upset
☐ Sun sensitivity (unusual skin reaction, not sunburn) ☐ Allergy: _______________

PSYCHOLOGICAL/SOCIAL
☐ Depression ☐ Behavior problem ☐ Learning difficulties
☐ Anxiety ☐ Attention difficulties ☐ OCD Tendencies

Indicate Previous Test(s) Performed	Date of Test	Location of Test
EEG		
MRI		
CT Scan		
Neuropsychological Testing		
Muscle biopsy		
EMG		
Drug Levels		
Does your child see any of the following specialists?	**Full** Name of Physician	Date of last visit
Diagnosing Physician and		

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Parent Initials _______ SUP Initials________

Physical Therapist		
Occupational Therapist		
Speech Therapist		
Psychologist		
Neurosurgeon		
Geneticist		
Other:		

NEW PATIENT INTAKE FORM

PRIMARY CONCERN/REASON FOR TREATMENT

____
____
____
____
____
____
____

Does your child receive special education services? ☐ Yes ☐ No
Extracurricular Activities:
Past Therapies (circle all that apply): Physical/Occupational/Speech/Hippo/Vision/Water/Sensory Integration/Music

Parent Initials _______ SUP Initials________

Parent/Guardian Printed Name: ____
Parent/Guardian Signature: ____
Date: ___________

Reviewed by: ____
Date: ___________