NOVA ABA Therapy and Mental Health Services

New Client Intake Packet

Dear Parents/Caregivers,

Welcome to NOVA ABA Therapy and Mental Health Services! We are excited to begin a productive and meaningful relationship with you and your loved ones. Please review and complete the following information prior to your appointment.

- We require a prescription/order for the ABA services your child is to receive from his/her pediatrician or specialist (e.g., Developmental Pediatrician, Neurologist, or Psychiatrist) which should include a diagnosis code. Please fax, mail, or bring a copy / have a copy with you for your initial appointment.
- We also require an authorization from the insurance provider prior to providing any service. Our office will assist you in the process of procuring the authorization for the services.
- Please provide a copy of your insurance card and ID card (e.g., driver's license).
- Your child's initial assessment and program design will generally take about 5 hours. A portion of this time will be spent observing your child; a portion will be spent interviewing you and other natural supports, and a portion will be spent in the development and writing of the treatment plan.

We look forward to meeting with you and your child. If you have any questions, please do not hesitate to call.

Sincerely,

NOVA ABA Therapy and Mental Health Service

Intake Information

Client Information

Name:		D.O.B.:	Age:	SS#:
Address:		State:		Zip Code:
Sex:	Race:	Language:		
Home Phone:		Secondary Phone:		
Emergency Contact:		Emergency Contact Phone:		
Primary Physician:		Primary Physician Phone:		
Referring Provider:		Referring Provider Phone:		

Guarantor Information

Name:	D.O.B.:		SS#:
Address:	State:		Zip Code:
Home Phone:	Secondary Phone:		
Employer:	Employer Phone:		
Employer Address:	Employer State:	Employer Zip Code:	

Insurance Information

Primary Insurance:	Secondary Insurance:
ID#	ID#
Group #:	Group #:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

Authorization to Pay Benefits to NOVA ABA Therapy and Mental Health Services

I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or NOVA ABA Therapy and Mental Health Services.

Authorization to Release Medical Information to NOVA ABA Therapy and Mental Health Services

I authorize my provider, NOVA ABA Therapy and Mental Health Services, to release any information necessary for my course of treatment.

Authorization to Leave Messages

To include information pertaining to my treatment and/or office updates by the following method (please check: Yes or No)

☐ Yes ☐ No: Home answering machine
☐ Yes ☐ No: Cell phone voicemail
☐ Yes ☐ No: With authorized contact

☐ Yes ☐ No: Email: ____

Client / Guardian Signature:____ Date: ______________

HIPAA Information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I acknowledge that I contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices* from time to time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name: ____

Relationship to Client: ____

Client / Guardian Signature:____ Date: _____________

PROVIDER CONTACT INFORMATION

NOVA ABA Therapy and Mental Health Services
7617 Little River Turnpike Suite 110 Annandale VA 22003
Phone: 571-355-6980. Fax: 703-663-8730
Email: info@abatherapyofvirginia.com

OFFICE USE ONLY

I attempted to obtain the client's or authorized representative's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_______________Initials:_______________Reason: ____

Authorization to Release Confidential Information

(REGULATION 80.B)

RE: ____

D.O.B.: ___________________

I authorize NOVA ABA Therapy and Mental Health Services, to:

1. exchange information with: ____
2. release information to: ____
3. receive information from: ____

____

Name of Person, Organization, or Institution

____

Address

The following information:

- ☐ Medical Records
- ☐ Education / Academic Records
- ☐ Psychiatric Records
- ☐ Behavioral Report
- ☐ Teacher's Report
- ☐ Psychological Evaluation
- ☐ Neurological Evaluation
- ☐ Verbal Exchange
- ☐ Other Information: _______________________

Purpose of Disclosure or at the Request of the Individual:

As the person signing this authorization, I understand that I am giving my permission to the above named entity for disclosure of confidential records. I understand I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my records and is not effective as to records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I understand that information disclosed under his authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such information was protected by law while solely in the possession of the care entity.

Approximate Dates of Service: ____

For Purpose of: ____

Signature of Client / Guardian:____ Date: _____________

RELEASE VALID FOR (circle one): ONE YEAR TERMINATION OF TREATMENT REVOCATION

Authorization to Release Confidential Information
(REGULATION 80.B)

RE: ____

D.O.B.: ____________________

I authorize NOVA ABA Therapy and Mental Health Services, at 7617 Little River Turnpike Suite LL110 Annandale VA 22003 to:

1. exchange information with: ____
2. release information to: ____
3. receive information from: ____

____
Name of Person, Organization, or Institution

____
Address

The following information:

☐ Medical Records

☐ Education / Academic Records

☐ Psychiatric Records

☐ Behavioral Report

☐ Teacher's Report

☐ Psychological Evaluation

☐ Neurological Evaluation

☐ Verbal Exchange

☐ Other Information: ________________________

Purpose of Disclosure or at the Request of the Individual:
As the person signing this authorization, I understand that I am giving my permission to the above named entity for disclosure of confidential records. I understand I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my records and is not effective as to records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I understand that information disclosed under his authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such information was protected by law while solely in the possession of the care entity.

Approximate Dates of Service: ____

For Purpose of: ____

Signature of Client / Guardian: ____ Date: ______________

RELEASE VALID FOR (circle one): ONE YEAR TERMINATION OF TREATMENT REVOCATION

Authorization for Secondary Caregiver(s)

RE: ______________________________

D.O.B.: ___________

In my absence, I, the legal guardian for the above, authorize

____

Name of Person(s)

To Complete/Receive the Following:

☐ Sign Therapist Time Sheets

☐ Sign Daily Session Notes

☐ Be informed of Specific Treatment/Client Information

☐ Other: ____

____

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____

Purpose of Disclosure or at the Request of the Individual:
As the person signing this authorization, I understand that I am giving my permission to the above named entity to carry out responsibilities required for service provision in my absence. I understand I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my records and is not effective as to records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons. I understand that information disclosed under his authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such information was protected by law while solely in the possession of the care entity.

Signature of Client / Guardian:____ Date: ____________

Authorization for Secondary Caregiver(s)

RE: ________________________________

D.O.B.: ____________

In my absence, I, the legal guardian for the above, authorize

____

Name of Person(s)

To Complete/Receive the Following:

☐ Sign Therapist Time Sheets

☐ Sign Daily Session Notes

☐ Be informed of Specific Treatment/Client Information

☐ Other: ____

____

____

____

Purpose of Disclosure or at the Request of the Individual:
As the person signing this authorization, I understand that I am giving my permission to the above named entity to carry out responsibilities required for service provision in my absence. I understand I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my records and is not effective as to records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons. I understand that information disclosed under his authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such information was protected by law while solely in the possession of the care entity.

Signature of Client / Guardian:____ Date: _____________

Authorization for Video/Audio Recording

RE: ________________________________

D.O.B.: ____________

I give permission and consent for NOVA ABA Therapy and Mental Health Services to videotape and/or audio tape my child and/or me during the time my child is enrolled in 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 NOVA ABA Therapy and Mental Health Services and the family.

Comments (*please write any specific changes you require below related to the use of video/audio recording*):

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____

Signature of Client / Guardian:____ Date: _____________

Cancelation Policy

Regular attendance is very important for your child's progress in therapy. Your decision to receive ABA therapy from our agency is a commitment to your child and your child's therapy team. We maintain a cancelation policy, as outlined below, to assure efficient use of our therapists' time and skills.

We ask that cancelation occur at least 24 hours prior the scheduled session. When canceling a session, please contact your child's therapist as soon as possible to inform them of the cancelation.

Canceled session times can be rescheduled with your child's therapist depending on the therapist's availability.

If for some reason your child's therapist must cancel a session, you can expect at least 24 hours' notice prior to the scheduled session. Again, canceled session times can be rescheduled with your child's therapist depending on the therapist's availability.

Understanding that things do occasionally come up that precludes the provision of 24 hours' notice prior to canceling a session, we ask that communication between you and your child's therapist occur as soon as possible.

At NOVA ABA Therapy and Mental Health Services, we strive to provide as close to 100% of scheduled services as possible per month. We understand that things occur that sometimes do not allow for this. However, in assuring that proper service provision occurs, we require that no less than 80% of scheduled services to occur per month. The following entails the process that will occur should the 80% minimum not be met due to client cancelation.

1. If 80% of services are not rendered during a 2 consecutive month period, a meeting will be held with the team to determine if changes need to occur to the schedule. A Plan of Corrective Action will be implemented to ensure service provision increases to at least 80% during the following month.

2. If 80% of services are not rendered following the Plan of Corrective Action and remain below the 80% criteria for 3 consecutive months, NOVA ABA Therapy and Mental Health Services reserves the right to deny ongoing therapeutic services.

NOVA ABA Therapy and Mental Health Services does not collect cancellation fees for missed appointments.

Weather Policy

We are a private therapy clinic and we do not operate in coordination with public or private school systems. During times of inclement weather any closings and / or delayed opening information will be available by calling our office (703) 639-0950. If you are receiving in-home based ABA therapy, your child's therapist will contact you to discuss the options for that day's session.

Sick Policy

If your child becomes ill and has a fever or vomits, 24 hours must pass without either / or before your child can receive therapy.

Please contact your child's therapist as soon as possible to inform them that your child will not be able to be seen on that day.

By signing below, I acknowledge receipt of this cancelation policy and agree to the terms stipulated above.

Client / Guardian Signature:____ Date: ______________

Intake Assessment

Instructions: please complete the following questionnaire regarding your child's current presentation and needs. This information, along with preliminary assessment results will be used to develop an initial treatment plan for your child. If you are unsure how to answer any of the below questions, please either call the main office or leave it blank and it will be reviewed with the assigned supervisor.

- ✓ *Please make copies of any assessments or plans that have been completed for your child within the past 10 years. Appropriate documents might include Individual Education Programs, Behavior Intervention Plans, Psychological testing, Neurological testing, Educational testing, or other Medical testing.*

Please briefly describe the onset and age of concerns.

Social history

Behavioral history

Family history

Developmental history

Cognitive functioning

Have previous treatments/interventions been tried with the child? If yes, what were the outcomes?

Medical Information

Allergies:

Recent Physical Complaints & Medical Conditions:

Nutritional Needs:

Chronic Conditions:

Communicable Diseases:

Restrictions on Physical Activities, if any:

Past Serious Illness, Serious Injuries, & Hospitalizations:

Diagnoses:

Medical Treatments/Medications:

Fall Risk? If yes what strategies are used to prevent falls:

Health Status of Parents, Siblings, and/or Caregivers:

Psychiatric and Substance Issues Including Current Mental Health or Substance Use Needs, Presence of Co-Occurring Disorders, History of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues.

History of Abuse, Neglect, Sexual, or Domestic Violence, or Trauma including Psychological Trauma.

Daily Living Skills (include personal hygiene; play skills, responsibilities at home).

Social Skills (include strengths and weaknesses).

Community/Life Skills (needs/concerns/preferences for when or if in the community).

Housing Arrangements

Fall Risk, Communication Methods, or Needs, and Mobility and Adaptive Equipment Needs.

Please describe any environmental concerns / issues your child may have and what has worked well in the past (e.g., is agitated in crowded stores, is frightened by thunder and lightning).

Are there are health concerns/ gait concerns which need to be addressed in inclement /severe weather? (This can include not being outside when it is below a certain temperature or above a certain temperature, not walking where there is ice or snow).

Please think about the following:

In the event of an emergency we may have to leave the home when you are not present. Who are we to contact /where would you prefer we go if we have that choice (Example: this may be due to us smelling gas in the home, or the area is evacuated by emergency personnel due to flash flooding). What "MUST" we bring for your child to be as comfortable as possible IF we have time to get the item(s)? What medications MUST come with us?

Does the child engage in any behaviors that are a concern (i.e., dangerous to self or other)?

If the child does engage in behaviors that are a concern, what has been done in the past to address these? Has anything worked well? Anything that did not work well?

Please describe your child's likes and dislikes.

Please describe any notable strengths and/or weaknesses.

Please describe your goals for your child. What would you like to see as a result of the therapy?

When was the last time, if ever, your child saw one of the following specialists?

Pediatrician:

Neurologist:

Developmental Pediatrician:

Medication Management:

Psychiatry/Counseling:

Private Speech Therapy:

Private Occupational Therapy:

Private Physical Therapy:

Private Behavior Therapy/ABA:

Family Counseling:

Family Training in ABA:

Residential/Inpatient Treatment:

Please describe your child's average daily schedule.

Are there any unresolved conflicts? How is the relationship between the client and other family members? What does the family support system look like? Do the parents work outside the home? If so, who is responsible for caregiving during after school hours, school holidays, school breaks, and on weekends?

Are there any additional financial resources? Do you have a Medicaid waiver? What about other insurance policies?

What school and grade is the client in? Does he/she receive special ed services? Is there a current IEP? What services is the client receiving at school (PT, OT, Speech, 1: 1 aide, self-contained class or inclusion, etc.)? How is the client's academic performance? What behaviors does he/she have at school? Has the client ever been suspended/expelled? Any changes in academic performance based on the negative behaviors?