



Intake Packet

Requirements to Begin ABA:

1. **Complete Intake Packet and return to Behavior Matters via mail, fax, or in person.**

Behavior Matters, LLC
16941 North Eagle River Loop Road, Suite #3
Eagle River, AK 99577

Email: bxmatters@gmail.com
Fax: (907) 726-5366

2. **Provide Insurance Information.** If your insurance is Tricare (UnitedHealth Military & Veterans), United Behavioral Health or Premera BCBS of Alaska, we will need to verify insurance coverage prior to providing services. Pre-authorization is usually required for these insurances.
3. **Contact Behavior Matters to schedule evaluation.** Evaluations for ABA therapy take from 2-3 hours. Please plan to come 15 minutes prior to complete paperwork and plan to stay with your child for the full amount of time. Once the evaluation is complete, we will discuss recommendations for a plan of treatment and schedule therapy.



Insurance Reimbursement Form

Date: _____ Client's Name: _____ D.O.B _____

PRIMARY Insurance

Subscriber Name: _____ D.O.B _____ M ___ F ___

Spouse Name: _____ D.O.B. _____ M ___ F ___

Insurance Company: _____ Phone#: _____

Identification Number: _____ (full SSN of Sponsor for Tricare) Group/Plan Number: _____

Employer: _____

Insured's Phone #: _____ Insured's Email: _____

Spoke to: _____ Office use only

**Please provide us with a copy of the front and back of your insurance identification cards.*

SECONDARY Insurance (if applicable)

Subscriber Name: _____ D.O.B _____ M ___ F ___

Spouse Name: _____ D.O.B. _____ M ___ F ___

Insurance Company: _____ Phone#: _____

Identification Number: _____ Group/Plan Number: _____

Employer: _____

Insured's Phone #: _____ Insured's Email: _____

Spoke to: _____ Office use only

Insurance Verification (For Office Use Only)

Deductible: Individual. \$ _____ /Fam. \$ _____ Amount Met: Individual. \$ _____ /Fam. \$ _____

Co-Pay: \$ _____ Co-insurance: _____ % Lifetime Max: \$ _____

Does treatment need to be pre-certified? _____

of ABA Units: _____ # of ABA Units Used: _____

Covered Dx Codes: _____

Exceptions: _____

Verified by: _____ Date: _____



Behavior Matters Financial Agreement

New Patients approved for ABA therapy services are responsible for any and all charges not paid for by healthcare insurance payers (private or public). By signing this client agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Behavior Matters for the services we provide to you, our valued customer. Following the receipt of your patient statement, please contact us to make payment arrangements. We accept cash, personal checks, money orders and pay pal.

Each healthcare insurance payer has different guidelines for allowing coverage of ABA therapy. It is helpful if you let us know your healthcare payer when starting service so that we may find out if prior authorizations are needed. If your healthcare insurance payer is an insurance that we do not contract with, you are required to make self pay arrangements for the usual and customary pricing of our services (see self-pay rates below). We will provide you with a detailed invoice of services rendered on a weekly basis, so you may submit to your insurance. For non-contracted insurance payers and private pay clients, initial assessment fees to be collected at time of assessment, assessments last 4-10 hours based on complexity, to include 2 hours of report writing (please call for rates), and regular scheduled ABA sessions, payment is due at time of service.

My signature below signifies that I have read and understand this client agreement for Behavior Matters for ABA therapy services. I agree to the terms in this agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

We currently are contracted with the following insurances: Tricare (UnitedHealth Military & Veterans), United Behavioral Health and Premera BCBS of AK & Nebraska.

Signature of Client or Guardian/representative (or Witness if signature is by mark) Date:
Printed Name of Guardian/Representative:

This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of time. Please feel free to add any additional information which you think may be helpful in understanding your child. Please use the backs of the pages for additional information.



PLEASE PRINT

Person Completing this form: _____ Relationship to Child: _____

Child's Name: _____ D.O.B. _____ M _____ F _____

Nickname or name child routinely goes by: _____

Home Address: _____

Street

_____ City

_____ State

_____ Zip

Parent/Guardian	Home #	Work #	Cell	Email
Mother				
Father				

Preferred form of contact Home phone Cell phone Work phone Email

Caregiver Contact Information: Name: _____ Cell: _____

For Military: Sponsors Rank: _____ SSN: _____

Primary Physician: _____ Phone: _____

Fax: _____

Referring Physician: _____ Phone: _____

Fax: _____

FAMILY INFORMATION

Mother's Name: _____ DOB: _____ Occupation: _____

Father's Name: _____ DOB: _____ Occupation: _____

Parents are: Married ___ Divorced ___ Separated ___ Widowed ___ Single ___

• If divorced, who has physical custody? _____ Is it full or joint? _____

• Who has legal custody? _____ Is it full or joint? _____

Is this Child: ___ Your Biological Child ___ Step Child ___ Adopted Child ___ Foster Child

Persons living in the home: _____

MEDICAL HISTORY

Is your child currently in good health? ___ YES ___ NO

Do you have concerns regarding your child's hearing/vision? _____



PT			
----	--	--	--

Communication Skills: Primary method of communication: Picture Communication Sign Language ACC Verbal Gestures

Comments: _____

Barriers to Communication: Impaired Articulation Impaired Mand Impaired Tact Echoic Scrolling Impaired Echoic Impaired Intraverbal Prompt Dependent Weak Speaker Skills Weak Listener Skills Weak Interpretation of Non-Verbal Communication

Comments: _____

Social and play:

Does your child seek out interaction with Parents Siblings Other adults Peers
Does your child play Independently Next to other children only by him/herself?
What play skills does your child have? Plays with toys appropriately play easy card games appropriately play board games Takes turns following the rules of the game Keeps score

Comments: _____

Behavior: Physical stereotypical behavior Verbal stereotypical behavior Perseverations

Comments: _____

Challenging behavior: Physical aggression Self-injurious behavior Running Verbal aggression Yelling, screaming other _____

Triggers (if known): _____



Settings: _____

Frequency: _____

Intensity: _____

Function of the behavior To get attention to escape, avoid non-preferred tasks, demands to get preferred items, activities for no obvious reasons

Variables that may contribute to aversive behaviors & impede learning: Auditory Noise
 Visual Distractions Environment Time Crowds Proximity to others Transitions
 Limited MO's Failure to Generalize Negative Behaviors Lack of Instructional Control
 Impaired Motor Imitation Sensory Defensive Impaired Visual Perceptual Skills Impaired Social Skills
 Prompt Dependent Impaired Scanning Impaired Attending Reinforcement Dependent
 Self Stimulation Obsessive-Compulsive Behaviors Hyperactive Behaviors

Adaptive Living Concerns: Toileting Eating Dressing Independent Play Social Play
 Group Skills Fine Motor Gross Motor Household Routines Bathing Tooth brushing
 Hair Cleaning Cooking Leisure Time

PARENT/FAMILY PRIORITIES & PREFERENCES

Top three areas/goals you would like to see change for your child in next 6 months:

- 1.
- 2.
- 3.

Preferred schedule: Are you interested in ABA services at school? Yes/no

	Monday	Tuesday	Wednesday	Thursday	Friday
Time *					
Location**					

*Usually sessions at the clinic or in the home are 2-3 hours; at school/daycare sessions might be longer, but are still at least 2 hours. Our hours are for sessions are usually between 9am and 7 pm on weekdays. Based on child's needs we can do sessions (in school or home) earlier or later in the day, or on weekends.

** We are providing services in various locations based on child's needs, such as clinic, family home, school, and daycare and afterschool programs.

The following materials (with *) are required for insurance authorizations. Please include the following with this application, if applicable.

Provider	Document
	*Physician Diagnosis Reports
	*Most Recent Evaluation(s) (Neuro/ST/OT etc..)
	Progress Reports/ Written Service Plans



16941 No. Eagle River Loop Rd, Eagle River, AK 99577 (907) 726-5330 behaviormatters@gmail.com 7200 S. 84th St AltaVista,
NE 68128, 2401 Waterman Blvd 4A-208, Fairfield, CA 94534

	*Current IEP/ IFSP
	Behavior Intervention Plan
	Other Related Reports