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.

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

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.

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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? _____

Diagnosis	ICD-9 or DSM codes	Diagnosing Doctor	Date Diagnosed

Family Mental Health History: (check all that apply/list relation to client)

Relation	Relation	Relation
__Autism_____	___Bipolar_____	___Depression_____
__ADHD_____	___Anxiety_____	___Other_____
		_____

Is your child taking any medications? (Please list):

Medication	Dosage	Purpose	Prescribing Doctor

Please list any **allergies** your child has: _____

Other medical conditions/information: _____

_____

EDUCATIONAL HISTORY

School Name: _____ System: _____ Grade: _____
Is your child in school for a full day? _____If not – how many hours? _____
Current Teacher(s): _____
Does your child's teacher have concerns about him/her?: _____
_____

Please list special education services your child receives (IEP/504/behavior plan): _____
_____

Has your child ever received Applied Behavior Analysis (ABA)? If yes, how long, and when was the last date of services _____

Does your child receive SLP/OT/PT services at school and outside of the school?

Provider	How many hours at school?	Hours outside of school?	Total hours
SLP			
OT			

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

	*Current IEP/ IFSP
	Behavior Intervention Plan
	Other Related Reports