Intake Packet

Requirements to Begin ABA:

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

   Behavior Matters, LLC
   16941 N. Eagle River Loop Rd.
   Eagle River, AK 99577

   Email: officeak@behaviormattersllc.com
   Phone: (907) 726-5330
   Fax: (907) 726-5366

2. **Provide Insurance Information.** We will need to verify insurance coverage prior to providing services. Pre-authorization is usually required for these insurances. Please provide a copy of the front and back of your insurance card upon arrival to your scheduled assessment.

3. **Contact Behavior Matters to schedule evaluation.** Evaluations for ABA therapy could take about 2-3 hours. Sometimes the assessment needs to be done in several observations in a variety of settings. Please arrive 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.

4. **Attachments:**
   Please attach the most recent
   -IEP/504
   -Neuropsych assessment or any other evaluations
   -Previous Behavior plan

5. Depending on your child's insurance requirements we may send you an additional questionnaire that will need to be completed prior to the in-person assessment.

16941 N. Eagle River Loop Rd. Eagle River, AK 99577 (907) 726-5330 officeak@behaviormattersllc.com / 7905 L. St. Ste 230 Omaha, NE 68127 / 2401 Waterman Blvd 4A-208, Fairfield, CA 94534

Insurance Reimbursement Form

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

Does the recipient have and IDD Waiver (State of Alaska)? If yes, please list the name of the Directing Clinician
☐ NO ☐ YES _____

Insured's Information: PRIMARY

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: _____

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

Insured's Information: SECONDARY (if applicable)

Name: _____ D.O.B_____ M___F____

Insurance Company: _____ Phone#: _____

Identification Number: _____ Group/Plan Number: _____

Employer: _____

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

Spoke to: _____

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.

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

Childs SSN:_____

Nickname or name child routinely goes by:

_____

Home Address: _____

Street

_____ _____ _____

City State Zip

Current Living Situation: ☐ Assisted Living Home ☐ Foster Home ☐ Recipient's Private Residence ☐ Residential Child Care Facility ☐ Other: _____

Parent/Guardian	Home #	Work #	Cell	Email
Mother				
Father				
Other				
Other				

Preferred form of contact ☐Home phone ☐ Cell phone ☐ Work phone ☐ Email

Caregiver Contact Information: Name: _____ **Cell**: _____

Primary Physician: _____ **Phone**: _____

Fax: _____

Referring Physician: _____ **Phone**: _____

Fax: _____

FAMILY INFORMATION

Mother's Name: _____ **Age**: _____ **Occupation**: _____

Father's Name: _____**Age:** _____ **Occupation:** _____

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

- **Who has legal custody**? ☐ Mom ☐ Dad ☐ JJ- Juvenile Justice ☐ OCS- Office of Child Services

- **Is it full or joint**? ☐ Full ☐ Joint

- **If in custody by OCS or Juvenile Justice, Case Worker's name**: _____

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
- **Please list any allergies your child has**: _____
- **Do you have concerns regarding your child's hearing/vision?** ☐ Hearing ☐ Vision ☐ No
- **Select Co-Morbidity**: ☐ Complicated Medical ☐ Developmental D/O ☐ Eating D/O ☐ FASD ☐ Hx of Brain Injury ☐ Medical Disability ☐ Mood D/O ☐ Substance Abuse ☐ Suspected FASD ☐ Thought D/O ☐ None Identified ☐ Other: _____

Diagnosis	ICD-10 or DSM codes	Diagnosing Doctor	Date Diagnosed

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

☐ Autism _____ ☐ Bipolar_____ ☐Depression_____
☐ ADHD _____ ☐ Anxiety _____ ☐ Other _____

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

***We do not administrate medications, this information is required for assessments/some insurences**

Medication	Dosage	Purpose	Prescribing Doctor

Other medical conditions/information: _____

_____

EDUCATIONAL HISTORY

School Name: _____ **System**: _____ **Grade**: _____
Is your child in school for a full day? ☐ Yes ☐ No **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, who was the provider, how long, and when was the last date of services

_____

What is their level of Cognitive Function (IQ)? ☐ Above 70 (Average) ☐ 55-70 (Mild) ☐ 35-54 (Moderate) ☐ 20-34 (Severe) ☐ Below 20 (Profound) ☐ Unknown

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 ☐ plays 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 _____

Intensity: ☐ Mild ☐ Moderate ☐ Severe **Comment:** _____

Triggers (if known): _____

Settings: _____

Frequency: _____

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:

	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 for sessions are usually between 8am and 7 pm on weekdays. Based on child's needs and staff availability, 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 (If School District approves), and daycare and afterschool programs.