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### Initial Intake Form

Child's full name: \_\_\_\_\_  
(First) (Middle) (Last)

Date of birth: \_\_\_\_\_

#### Parent/Guardian Information:

Parent 1 name: \_\_\_\_\_  
(First) (Middle) (Last)

Parent 2 name: \_\_\_\_\_  
(First) (Middle) (Last)

Primary address: \_\_\_\_\_  
\_\_\_\_\_

Home phone number: (\_\_\_\_) \_\_\_\_\_

Parent 1 Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Parent 1 Cellular: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Parent 2 Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Parent 2 Cellular: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

#### Medical Information:

Name of physician: \_\_\_\_\_

Physician address: \_\_\_\_\_

Physician phone: (\_\_\_\_) \_\_\_\_\_

Does your child have any current health condition? If so, please explain below

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Please list any medications that your child is currently taking.

Name of medication	Amount	When taken	State reactions

Does your child currently have any diagnoses? If so, please state below.

Diagnoses	Diagnosing physician	Date diagnosed	Diagnosis Code

**Insurance Information:**

Name of Insurance Company: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

**Educational Information:**

Does your child attend school? If so, please complete the information below.

Name of school: \_\_\_\_\_

Teacher/Grade: \_\_\_\_\_

Address: \_\_\_\_\_

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School Phone number: (\_\_\_\_) \_\_\_\_\_

Please state your child's behaviors of concern:

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Please state the expectations/goals that you have for your child while engaging in a behavioral program:

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Please list any other information that may be helpful while assessing and/or conducting therapy with your child:

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Please state the preferred clinic location (Wesley Chapel or Westchase), number of therapy hours (for Verbal Behavior Programs), and dates/times that would be most convenient for your child and your family, if applicable:

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Referred by: \_\_\_\_\_

\*Please attach any assessments or evaluations that may aid in developing your child's program or behavioral interventions.

## Verbal Behavior (ABA/VB) Program Information

### *Description*

Our verbal behavior program is designed for children who have a diagnosis or are lacking skills. It includes 1:1 therapy from a trained behavior therapist for a minimum of 10 hours per week to teach skills such as language/communication, self-help skills, social skills, academic and compliance skills.

### *Intake Procedure*

An initial assessment is conducted (ABLLS) with you and your child which takes approximately 2 hours depending on the skill level of the child. Based on the information received from the assessment, the following programs may be recommended:

#### 10-hour program

- 10 hours per week of direct instruction by a trained verbal behavior therapist
- Weekly program review and maintenance by BCBA or BCABA
- Supervision of program by BCBA
- Complimentary phone calls and emails
- Up to 30 minutes of face-to-face/phone consult per month (at the clients request)
- Monthly program updates by BCBA or BCABA

#### 20-hour program

- 20 hours per week of direct instruction by a trained verbal behavior therapist
- Weekly program review and maintenance by BCBA
- Supervision of program by BCBA
- Complimentary phone calls and emails
- Up to 30 minutes of face-to-face/phone consult per month (at the clients request)
- Monthly program updates by BCBA

#### 30-hour program

- 30 hours per week of direct instruction by a trained verbal behavior therapist
- Weekly program review and maintenance by BCBA
- Supervision of program by BCBA
- Complimentary phone calls and emails
- Up to 30 minutes of face-to-face/phone consult per month (at the clients request)
- Bi-weekly program updates by BCBA
- Prepaid monthly - 5% discount
- Prepaid quarterly - 10% discount

\*fees for Verbal Behavior Program are due at the end of each therapy week with the exception of programs covered by insurance

## **Behavior Reduction Program Information**

### ***Description***

Our behavior reduction program is designed for children who may or may not have a diagnosis but who engage in disruptive behavior in the home, school, or community settings. It includes conducting a records review, an interview with the parents/school staff, observations of the behavior in the setting in which it occurs, developing written recommendations, and training parents/school staff on proper implementation of the interventions.

### ***Intake Procedure***

A Functional Assessment Interview is conducted with the parents/school staff in order to get information regarding the behaviors of concern.

### ***Behavior Reduction Program Package***

The Behavior Reduction Package includes all services listed below while additional services are billed at an hourly rate.

### **Behavior Reduction Program Package**

- Initial Behavior Interview with family and/or school staff at our office
- Records review
- 2-hour observation of problem behavior in 1 community setting
- Review data collected by family and/or school staff
- Develop formal written recommendations
- Review of recommendations with family and/or school staff at our office
- 2-hour follow-up home/school visit to model recommended interventions

### **Additional Services (billed per quarter hour)**

- Additional observations of problem behavior
- Additional modeling of behavior interventions for family and/or school staff in community setting
- Observing parents/school staff implementing interventions and providing feedback to parents/school staff regarding their implementation of behavior plan
- Addressing additional behaviors that develop upon completion of initial behavior assessment
- Additional home visits or office consults to discuss problem behaviors
- Follow-up services, as needed

\*Fees for services shall be paid in full at the time of the Initial Behavior Interview

## **Additional Services Offered**

### **Intensive Feeding Program**

#### ***Description***

Our intensive feeding program is designed for children with limited diets who can not tolerate foods from a variety of food groups or novel foods.

#### ***Intake Information***

An initial feeding assessment is conducted with the parents in order to identify the foods that are tolerated and the foods that will be targeted during feeding therapy.

#### ***Feeding Program Schedule***

The feeding program consists of 1-2 days per week of therapy for 2 hour sessions.

### **Intensive Toilet Training Program**

#### ***Description***

Our errorless toilet training program is a 3-day program (36 hours) in which trained staff work with your child 1:1 at your home to teach independent toileting skills.

#### ***Intake Information***

A toilet training intake meeting will be conducted with the parents at our office

\*BCOTB clients receive a 10% discount on toilet training program

## Fee Agreement

I/we \_\_\_\_\_ agree to pay Behavioral Consulting of Tampa Bay, Inc. for all services when services are rendered. If my insurance carrier provides financial assistance for services, I/we do understand that I need to pay the fees at the time services are rendered and allow the insurance carrier to reimburse me/my family unless a current authorization to cover services is on file. If I am receiving funding from an outside funding source or agency, I do understand that the funding source/agency will be billed for services rather than me/my family. I do agree to pay for the services, though, if the claim is not approved by the outside funding source. Payments for services are listed below and billed per quarter hour. The fees may be adjusted at any time without prior notice.

Costs of services:

Behavior Analyst (BCBA) services:

\$90.00 per hour for center-based services  
\$100.00 per hour for services provided outside  
of the center within a 20 mile radius  
For consults exceeding 20 miles from the clinic, the fee  
will be determined on a 1 to 1 basis

Associate Behavior Analyst (BCABA) services:

\$70.00 per hour for center-based services  
\$80.00 per hour for services provided outside  
of the center within a 20 mile radius  
For consults exceeding 20 miles from the clinic, the fee  
will be determined on a 1 to 1 basis.

Therapy services provided by a verbal behavior therapist:

\$50.00 per hour for center-based therapy

Tutoring services: same as therapy services

School shadow: same as therapy services

Phone consults: same as the center-based rates for the BCBA or the  
BCABA (depending on who is conducting phone consult).

We understand that emergencies and illnesses arise which may cause a session to be cancelled. We have reserved your consult/therapy time for your family and, therefore, request that we be notified at least 24 hours in advance of any cancellation. If notification is not made at least 24 hours in advance and there is not an emergency

situation, you will be billed for your regularly scheduled session. In the event of an unexpected illness in which 24 hours notice can not be made, Behavioral Consulting requires at least a 3 hour notice to cancel an appointment to prevent being billed for the entire session. If a client arrives late to a scheduled appointment, the client will be billed the rate of the full appointment. In addition, if a client is late to pick up their child at the end of the therapy session, the additional time will be billed at the therapy rate per quarter hour. Repeated failures to attend scheduled sessions or arrive late to scheduled sessions/pick up times may result in termination of services.

I/we have carefully read and agree to this Fee Agreement. I/we agree to abide by the terms stated above.

Parent 1 signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent 2 signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Release of Information

I/we agree that Behavioral Consulting of Tampa Bay, Inc has my/our authorization to release information regarding my child's assessment, program goals, progress on program goals, or any other information that may be helpful in developing a treatment plan to other professionals including, but not limited to, independent contractors hired by Behavioral Consulting, school staff, other family members, psychologists, Speech and Language Pathologists, Occupational Therapists, and medical personnel.

I/we understand that we may withdraw this agreement at any time, without prior notification, by providing Behavioral Consulting of Tampa Bay, Inc. with written notice. Upon receipt of this written notice, the request to revoke the release of information will be effective immediately.

\_\_\_\_\_  
Parent 1 Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent 1 Signature

\_\_\_\_\_  
Parent 2 Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent 2 Signature

## Treatment Contract

I/we \_\_\_\_\_ are entering into this contract with Behavioral Consulting of Tampa Bay, Inc. voluntarily. This contract will remain in effect from this date, \_\_\_\_\_, until either party wishes to terminate this agreement by giving written notice.

I/we agree to cooperate with Behavioral Consulting's efforts to provide services to my child and my family and I/we will participate in the treatment process and will follow through with any interventions recommended by Behavioral Consulting

Behavioral Consulting will supervise and monitor services provided to me by individual therapists and consultants. These therapists and consultants are employees of Behavioral Consulting and will be supervised accordingly.

I/we understand that Behavioral Consulting shall have exclusive responsibility and authority to make all professional judgments and decisions with reference to the services rendered to me/us and our family.

I/we understand that, if my child is participating in a 1:1 treatment program (Verbal Behavior Program) with Behavioral Consulting, a minimum of monthly to biweekly supervision is required to properly supervise the program, observe my child engaging in the recommended program, and make changes to his/her program. This typically takes between 1 1/2 to 2 hours and the therapists on my child's team must also be in attendance.

I/we understand that Behavioral Consulting will incur substantial costs in providing and arranging for the services to be provided to our family, including supplies, services, personnel, and other items that are the subject of this agreement. Accordingly, I/we promise and agree that, during the term of this agreement, and any extension to the agreement, plus one (1) year after the agreement expires, is terminated, or otherwise concludes:

I/we will not attempt to directly or indirectly own, manage, operate or control or participate in the ownership, management, operation or control of, or become associated, as an employee, director, officer, advisor, agent consultant, principal, partner, member or independent contractor with any person, enterprise, firm, partnership, corporation, limited liability entity, cooperative or other entity operating a behavioral consulting services firm or other competitive business located, or providing services, within a twenty (20) mile radius of the areas where Behavioral Consulting provides services.

I/we will not attempt to divert any business of Behavioral Consulting to any other competitive establishment that is located within a twenty (20) mile radius of the areas where Behavioral Consulting provides services.

I/we agree not to solicit or employ any employee or independent contractor of Behavioral Consulting, including Consultants or Therapists, in any manner including, but not limited to: as an employee, consultant, or through a third party, other than general advertisement, without prior written approval by Behavioral Consulting during the term of this

agreement and for at least two (2) years after the expiration, termination or conclusion of this agreement. Unless otherwise agreed to by the Parties, in the event that I/we violate this Section, I/we agree to pay Behavioral Consulting a fee of fifty percent (50%) of the gross annual salary paid by Behavioral Consulting to such employee or independent contractor, including Consultants and Therapists. Such fee shall be paid by me/us upon hiring of such employee or independent contractor, including Consultants and Therapists, in any capacity.

I/we agree to maintain confidentially for all business policies, procedures, techniques, trade secrets other knowledge or processes developed by Behavioral Consulting. I/we understand that all program materials are prepared solely for my/our use and can not be copied, disseminated, published, or shared with a third party without the approval of Behavioral Consulting. I/we understand that all program materials must be returned to Behavioral Consulting upon termination of this agreement.

I/we understand that there is a risk associated with any type of therapy or intervention. I/we agree that to the fullest extent permitted by law, Behavioral Consulting shall not be liable to Client for any special, indirect or consequential damages whatsoever, whether caused by Behavioral Consulting's negligence, breach of contract, or other cause or causes whatsoever including, but not limited to, loss of behavioral consulting services and the costs related to locating a new provider of such consulting services. This does not include willful or intentional wrongs.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,

<p><b>BEHAVIORAL CONSULTING OF TAMPA BAY, INC.</b>          6916 W Linebaugh Avenue, Suite 102          Tampa, Florida 33625</p> <p>3717 Turman Loop, Suite 102          Wesley Chapel, FL 33544</p> <p>By: _____          Kelley Prince, President</p> <p>By: _____          Jamie Granatino, Program Director</p>	<p><b>CLIENT</b></p> <p>_____</p> <p>_____</p> <p>Address</p> <p>By: _____</p> <p>Parent 1 Signature</p> <p>Print Name: _____</p> <p><b>AND</b></p> <p>By: _____</p> <p>Parent 2 Signature</p> <p>Print Name: _____</p>
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Rev 1/10