



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: _____

ANALYSIS • INSTRUCTION • ACHIEVEMENT

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Initials

Physician phone: (____)_____

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

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.

*Required for insurance coverage

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: _____

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Address: _____

School Phone number: (____) _____

Current/Previous Therapy Provider Information (please attach most recent evaluations):

Behavioral Provider Name: _____

Contact Name/Phone: _____

Dates of Service: _____

Please state the therapy outcomes:

Speech Therapy Provider Name: _____

Contact Name/Phone: _____

Dates of Service: _____

Please state the therapy outcomes:

Occupational Therapy Provider Name: _____

Contact Name/Phone: _____

Dates of Service: _____

Please state the therapy outcomes:

Other Therapy Provider Name: _____

Contact Name/Phone: _____

Dates of Service: _____

Please state the therapy outcomes:

Other Information:

Please state your child's behaviors of concern:

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

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

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:

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 autism or a similar disorder or children who 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-R) 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 or BCaBA
- 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 or BCaBA
- Supervision of program by BCBA or BCaBA
- Complimentary phone calls and emails
- Up to 60 minutes of face-to-face/phone consult per month (at the clients request)
- Monthly program updates by BCBA or BCaBA

30-hour program

- 30 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 or BCaBA
- 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 or BCaBA
- Prepaid monthly - 5% discount
- Prepaid quarterly - 10% discount

*Insurance clients will be billed for additional services such as monthly program updates, therapist supervision, development of insurance reports, and updating the child's ABLLS assessment

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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 the behavior 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 (if purchasing package)

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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 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 involved in an ABA/VB program receive a 10% discount on toilet training program

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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 a current insurance authorization is on file, I authorize Behavioral Consulting to file insurance claims on my behalf. I also agree to pay all copayments and fees for co-insurance at the end of each therapy week.

If a current insurance authorization is on file but claims are repeatedly denied, I/we understand that Behavioral Consulting may have to temporarily suspend services until payment has been received. This will only occur if claims are being denied for over 90 days.

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

Assistant 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

\$60.00 per hour for school-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 a cancellation fee equal to the amount of your financial responsibility for the regular scheduled 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: _____

*The fees listed above are the rates for private paying clients and may vary depending on funding source or insurance carrier

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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. I also understand that therapy outcome is dependent on several variables and success can not be guaranteed.

Executed this _____ day of _____, 20____,

<p>BEHAVIORAL CONSULTING OF TAMPA BAY, INC.</p> <p>6916 W Linebaugh Avenue, Suite 102 Tampa, Florida 33625</p> <p>3717 Turman Loop, Suite 102 Wesley Chapel, FL 33544</p> <p>By: _____ Behavioral Consulting Representative Printed Name</p> <p>By: _____ Behavioral Consulting Representative Signature</p>	<p>CLIENT</p> <p>_____</p> <p>_____</p> <p>Address</p> <p>By: _____ Parent 1 Signature</p> <p>Print Name: _____</p> <p>AND</p> <p>By: _____ Parent 2 Signature</p> <p>Print Name: _____</p>
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Rev. 11/11

Client entered into QB _____