Alabama Autism Assistance Program/ The HANDS Program

BEHAVIORAL THERAPY ENROLLMENT APPLICATION

CONTACT INFORMATION:

Date of Completion: __/____/_______ Name of Person Completing: ____________________________

Child's Name: ____________________________________ Date of Birth (mm/dd/yy): _____________

Age: ____________ ❑ MALE ❑ FEMALE

Referred by: ____

Parent #1 Name: ________________________________ Occupation: ___________________________

Parent #1 Phone Number: ______________________ Email: ___________________________________

Parent #2 Name: ________________________________ Occupation: ___________________________

Parent #2 Phone Number: ______________________ Email: ___________________________________

Address: ____________________________________ City: ________________ St:____ Zip:_________

Sibling(s) Name(s) & Age(s): ____

Emergency Contact: ___________________________ Phone Number: ____________________________

MEDICAL INFORMATION:

Diagnoses: ____

Date Diagnosed: ______________ Diagnosing Physician: _________________________________

Medications: ____

Special Diet: ____

Allergies: ____

CURRENT INTERVENTIONS:

School : ____________________________________ School Phone Number: ____________________

Grade: ______________ Setting: ____

Does your child receive Special Education Services? ❑ YES ❑ NO

If yes, amount of resource time: ____

Does your child have a 1:1 aide? ❑ YES ❑ NO If yes, % of day with child: _______________

SPEECH THERAPY SERVICES:

Therapist Name: ______________________________ Agency: ______________________________________

Date started : ___/____/______ Current Frequency of Service: _______________________________

Current goals: ____

OCCUPATIONAL THERAPY SERVICES:

Therapist Name: ______________________________ Agency: ______________________________________

Date started : ___/____/______ Current Frequency of Service: _______________________________

Current goals: ____

BEHAVIOR THERAPY SERVICES:

Therapist Name: ______________________________ Agency: ______________________________________

Date started : ___/____/______ Current Frequency of Service: _______________________________

Current goals: ____

Describe what concerns you have that prompted you to contact The HANDS Program. When did you first become concerned with your child's development?

DEVELOPMENTAL HISTORY:

Please provide, to the best of your ability, the approximate ages at which your child began to do the following activities:

_________Smile

________ Coo/Babbles

________ Roll over

________ Sit alone

________ Stand alone

_______ Speak phrases

_______ Speak sentences

________Toliet trained

________Crawl

________ Walk alone

________ Feed self

________ Dress self

________ Single words

How does your child communicate?

___ Crying ___ Sounds ___ Pointing ___ Words ___Phrases ___ Sentences

___ PECS ___Eye Gaze ___ Electronic Talking Device ___ Sign Language

How much of your child's speech is understandable?

___ Some ___ Most ___ All

Does your child have difficulty with any of the following?:

Understanding what others say ❑ YES ❑ NO Talking ❑ YES ❑ NO

Reading ❑ YES ❑ NO Math ❑ YES ❑ NO

Since you first became concerned with your child's development, how has he/she changed?

SOCIAL/LEISURE SKILLS:

Does Your Child:	Usually	Sometimes (spontaneously)	Sometimes (with prompting)	Rarely
make eye contact when interacting with others?				
return greetings from peers/ adults?				
initiate greetings with peers/ adults?				
initiate play interactions with peers?				
seek attention from others when a significant event occurs in the environment?				
play with toys as designed?				

Can your child play age appropriate games without adult assistance? ❑ YES ❑ NO

If no, when is assistance needed? (Circle all that apply)

Attending to turn Completing actions of game Coping with loss

Following rules of game Interacting with peers Other: ___________________

ACADEMIC SKILLS:

Can your child tolerate a group setting with structured lessons?

Yes, with teacher:student ratio 1:20+ Yes, 1:10 Yes, 1:5 Yes, 1:2 No

Can your child do table activities?

Yes, 30+ mins. Yes, 20+ mins. Yes, 10+ mins. Yes, 5+ mins.
Yes, 1-2 mins. No

For each of the academic areas listed below, please rate your child's performance and comment on specific issues that your child has in each area.

ACADEMIC AREA/ COMMENTS	ABOVE AVERAGE	ON GRADE LEVEL	BELOW AVERAGE
READING			
MATH			
SPELLING			
ENGLISH/LANG ARTS			
SCIENCE			
SOCIAL STUDIES/HISTORY			
WRITING			
OTHER			

MOTOR SKILLS:

Does your child have any significant gross motor issues? ❑ YES ❑ NO

If yes, plese explain, and list tasks that your child has difficulty completing due to gross motor skill deficits.

Does your child have any significant fine motor issues? ❑ YES ❑ NO

If yes, plese explain, and list tasks that your child has difficulty completing due to fine motor skill deficits.

Does your child have a hand preference? ❑ LEFT ❑ RIGHT

SELF-HELP/DAILY LIVING SKILLS

EATING/DRINKING

❑ Independent ❑ Minimal Assistance ❑ Some Assistance ❑ Full Physical Assistance

If assistance is required, please list the areas in which assistance is needed, and the amount of assistance provided.

TOILETING

❑ Independent ❑ Minimal Assistance ❑ Some Assistance ❑ Full Physical Assistance

If assistance is required, please list the areas in which assistance is needed, and the amount of assistance provided.

DRESSING

❑ Independent ❑ Minimal Assistance ❑ Some Assistance ❑ Full Physical Assistance

If assistance is required, please list the areas in which assistance is needed, and the amount of assistance provided.

SLEEPING

❑ Independent ❑ Minimal Assistance ❑ Some Assistance ❑ Full Physical Assistance

If assistance is required, please list the areas in which assistance is needed, and the amount of assistance provided.

DAILY ROUTINES/TRANSITIONING

❑ Independent ❑ Minimal Assistance ❑ Some Assistance ❑ Full Physical Assistance

If assistance is required, please list the areas in which assistance is needed, and the amount of assistance provided.

BEHAVIOR REINFORCER ASSESSMENT

Please list any problem behaviors (ex: hitting, crying, falling to ground, touching others, etc.) that your child displays. Estimate the number of times these behaviors happen (ex: 100 times/day, 10 times/week, etc.) List a few examples of when the behaviors occur (ex: morning, non-preferred tasks, told no, etc.). Describe what strategies you have tried to manage the behaviors and whether these strategies have been successful or not.

BEHAVIOR	FREQUENCY	SETTING EVENTS OR TRIGGERS	MANAGEMENT STRATEGIES	EFFECTIVENESS

Please list any sensory issues, narrow interests, repetitive behaviors, or rigid routines that cause problems.

Please list some of your child's favorite items or activities (toys, games, TV shows, movies, songs, topics, snacks, etc).

How would you describe your child? Please check all that apply.

❑ Very active ❑ Sometimes active, but can plan quietly ❑ Not active

❑ Unusally happy ❑ Moody ❑ Demands attention ❑ Aggressive towards self or others

Please list three goals you would like for your child to accomplish at The HANDS Program.

1.

2.

3.

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

Please attach copies of any recent IEP's, ISFP's, ILP's, FBA's, BIP's, BSP's, professional reports or evaluations to assist in ensuring this program will be appropriate to address your child's individual needs.

Please include a copy of the front and back of your insurance cards and a copy of your drivers license.

Alabama Autism Assistance Program/The HANDS Program
300 Shadow Wood Park, Suite 100
Birmingham AL 35244
Phone: 205-733-0976

Alabama Autism Assistance Program/The HANDS Program

GENERAL MEDIA RELEASE FORM

1. I, the undersigned, hereby authorize AAAP/HANDS to photograph me/my child, take video footage of me/my child, and/or make electronic sound recordings of me/my child (herein referred to as photographic or electronic reprodutions.)

2. I authorize the use of any such photographic or electronic reproductions of me/my child for any purpose, including, but not limited to educational and other public media (ex: social media, website, marketing materials, etc) as may be deemed appropriate by AAAP/HANDS. I understand that I/we may be identifable from such photographic and electronic reproduction.

AGREED AND ACCEPTED BY:

PRINT NAME: ______________________________

Address: ______________________________

City: ____________________ St:____ Zip:__________

Phone Number :(______) ______________________

Signature: ______________ Date: ______________

PARENTAL CONSENT:

I certify that I am the parent/guardian of individual above, ________________________, a minor under the age of eighteen years or legal dependent. I hereby agree to assume legal responsibility for his/her authorizations referred to in this General Media Release.

PRINT PARENT/GUARDIAN NAME: ______________________

Address: ______________________________

City: ____________________ St:____ Zip:__________

Phone Number :(______) ______________________

Signature: ______________ Date: ______________

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FINANCIAL AGREEMENT

PAYMENTS:
Timely payment of invoices is expected and appreciated. Invoices for all services rendered will be mailed at the beginning of each month for the month prior. Payment is due within ten days of of invoice. HANDS accepts cash, checks, debit cards, and all major credit cards. There will be a $35 fee for returned checks.

NO SHOW AND CANCELLAtION POLICY:
It is extremly important to be on time for your sessions in the center, home or school. If you are unable to keep your appointment, please call your therapist within 24 hours to reschedule or cancel to avoid a no show or late cancellation fee. If you do not show or cancel your appointment without 24-hour notice, we reserve the right to charge an hour of therapy as a fee.

If you are going to be late for an appointment, please contact the therapist as soon as possible. You may be asked to reschedule, in which case, an hour of therapy may be charged as a late cancellation fee. If there is any time missed due to being late, that time is not guaranteed to be made up within the session, and will still be charged as a full session.

PAST DUE ACCOUNTS:
Any past due accounts will be charged at $25.00 late fee. Accounts with balance due over 30 days past due will be charged to the credit/debit card on file. Failure to provide timely payment will result in interruption in services until invoice is paid in full. All accounts over 90 days past due will receive notice for discontuation of services, and will be placed into collections processing.

INSURANCE:
As a courtesy, we will glady verify your benefits and file your claims with your insurance company. You are responsible for any deductible, co-pays and/or co-insurance amounts. We will do our best to help you understand your insurance benefits. Please note that all payment decisions are made by your insurance company upon receipt of actual claim, and are soley based on your benefit plan. We do not make any guarantees regarding what an insurance company will cover and/or amount they will pay.

I understand that I am responsible for my bill. I hereby agree to pay in full, all amounts due for services rendered by The HANDS Program, no later than thirty days from the date services are rendered, unless other specific written arrangements have been made. In the event of default in payment of said services, I waive, as to the debt, all rights of exemptions and laws of Alabama or any other state as to the personal property, and agree to pay all cost associated with collections, or securing, or attempting to collect or secure said indebtedness, including all reasonable attorney fees and/or court costs. I authorize The HANDS Program to charge my debit/credit card on file for any balance due that is 30-days (or greater) past due. By signing below, I authorize The HANDS Program to collect payment for any debt I may accrue. I have read and understand the no show and cancellation policy. I have read the Financial Agreement written for The HANDS Program. I understand what I have read and agree to comply with the policies.

Client Name: ______________________________ Date: ________________

Signature of Responsible Party: ____________________ Date: ________________

PRINT Name of Responsible Party: ____________________

Alabama Autism Assistance Program/The HANDS Program

DEMOGRAPHIC SHEET

Date of Completion: __/____/_______ Name of Person Completing: ____________________________

Client's Name: ______________________________________Date of Birth (mm/dd/yy): _____________

Address: ______________________________________ City: ________________ St:____ Zip:__________

Home Phone Number : (____)_________________ Work Phone Number: (____)_________________

Cell Phone Number: (____)____________________ Email: _____________________________________

Age: _____________ ❑ MALE ❑ FEMALE Marital Status: _________________________________

INSURANCE INFORMATION:

Primary Insurance Company: ____

Policy/ID Number: ____

Group Number:___________________________________ Group Name:_______________________________

Subscriber/Guarantor's Name: ____

Subscriber/Guarantor's Date of Birth (mm/dd/yy): ____

Subscriber's Employer: ____

Relationship to PATIENT: ❑ Self ❑ Spouse ❑ Child ❑ Other: _______________________________

Secondary Insurance Company: ____

Policy/ID Number: ____

Group Number:___________________________________ Group Name:_______________________________

Subscriber/Guarantor's Name: ____

Subscriber/Guarantor's Date of Birth (mm/dd/yy): ____

Subscriber's Employer: ____

Relationship to PATIENT: ❑ Self ❑ Spouse ❑ Child ❑ Other: _______________________________

I authorize The HANDS Program to release or receive any information necessary to expedite insurance claims. I authorize this office to bill my insurance company directly for their services. I authorize payment directly to this provider of any insurance benefits otherwise payable to me. I the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to this provider for which these fees are payable.

Signature of Responsible Party: ______________________________ Date: _____________________

PRINT Name of Responsible Party: ____________________________

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