Alabama Autism Assistance Program/ The HANDS Program

# BEHAVIORAL THERAPY ENROLLMENT APPLICATION

**CONTACT AND PERSONAL 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: _____ State:_____ Zip Code:_____

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

Emergency Contact: _____ Phone Number: _____

Please select which office(s) you would like to receive services at:

❑ Birmingham, AL

❑ Tuscaloosa, AL

❑ Alexander City, AL

**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: _____

**REASONS FOR SEEKING SERVICES:**

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

_____

_____

_____

_____

ALABAMA AUTISM THE HANDS PROGRAM ASSISTANCE PROGRAM

**DEVELOPMENTAL HISTORY:**

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

_____Smile _____Speak phrases _____Walk alone _____Coo/Babbles _____Speak sentences
_____Feed self _____Roll over _____Toliet trained _____Dress self _____Sit alone _____Crawl
_____Single words _____Stand alone

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?_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALABAMA AUTISM
THE HANDS PROGRAM
ASSISTANCE PROGRAM

**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 from peers/adults?** | | | | |
| **Initiate play interactions with peers?** | | | | |
| **Seek attention from others when a significant event occurs?** | | | | |
| **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/Language Arts** | | | |
| **Science** | | | |
| **Social Studies/History** | | | |
| **Writing** | | | |
| **Other** | | | |

**MOTOR SKILLS:**

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

If yes, please 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, please 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 |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

ALABAMA AUTISM
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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

❑ Unusually 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 driver's license.

ALABAMA AUTISM
THE HANDS PROGRAM
ASSISTANCE 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 reproductions.)

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 identifiable from such photographic and electronic reproduction.

**AGREED AND ACCEPTED BY:**

PRINT NAME: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone Number :(_____) _____

Signature: _____ Date: _____

**PARENTAL CONSENT:**

I certify that I am the parent/guardian of the 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: _____ State:_____ Zip:_____

Phone Number :(_____) _____

Signature: _____ Date: _____

Alabama Autism Acceptance Program/ The HANDS Program
300 Shadow Wood Park, Suite 100
Birmingham, AL 35244
Phone: 205-733-0976
Fax:205-533-7910

## DEMOGRAPHIC SHEET

Date of Completion: _____ /_____ /_____

Name of Person Completing:_____ Child's Name: _____

Date of Birth (mm/dd/yy): _____ /_____ /_____ Age: _____ ❑ MALE ❑ FEMALE

Address: _____

City: _____ State:_____ Zip Code:_____

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 AAAP/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. In 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:_____

PRINT Name of Responsible Party: _____

Date: _____ /_____ /_____

ALABAMA AUTISM THE HANDS PROGRAM ASSISTANCE PROGRAM

**NOTICE OF NONDISCRIMINATION POLICY AND ACCESSIBILITY**

Alabama Autism Assistance Program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Alabama Autism Assistance Program does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Alabama Autism Assistance Program:
- *Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- *Qualified sign language interpreters
- *Written information in other formats (large print, audio, accessible electronic
- formats, other formats)
- *Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our office at 205-733-0976.

If you believe that Alabama Autism Assistance Program has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Riley Williams, Chief Operating Officer of Alabama Autism Assistance Program
300 Shadow Wood Park, STE 100
Birmingham, AL 35244
Phone: 205-733-0976
Fax: 205-533-7910

You can file a grievance by mail, fax, or email. If you need help filing a grievance, we are available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**LIMITED ENGLISH PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES**
**Spanish**: ATENCIÓN: Si usted habla español, los servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame a 205-733-0976

## Alabama Assistance Program/The HANDS Program
## Notice of Privacy Practices and HIPAA Policy

**THE PRIVACY RULE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) REQUIRES US TO MAINTAIN THE PRIVACY OF MEDICAL INFORMATION PROVIDED TO US, PROVIDE NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES, AND ABIDE BY THE TERMS OF OUR NOTICE OF PRIVACY. THIS NOTICE DESCRIBES HOW ALL MEDICAL INFORMATION ABOUT THE CLIENTS WE SERVE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**
**THIS NOTICE DESCRIBES THE PRACTICES OF ALABAMA AUTISM ASSISTANCE PROGRAM (AAAP) EMPLOYEES AND STAFF. THIS NOTICE APPLIES TO EACH OF THESE INDIVIDUALS, ENTITIES, SITES, AND LOCATIONS. IN ADDITION, THESE INDIVIDUALS, ENTITIES, SITES, AND LOCATIONS MAY SHARE MEDICAL AND OTHER PRIVATE INFORMATION WITH EACH OTHER FOR TREATMENT, PAYMENT, AND HEALTH CARE SERVICE OPERATIONS FOR PURPOSES DESCRIBED IN THIS NOTICE. PLEASE REVIEW CAREFULLY.**

I. Uses and Disclosures for Treatment, Payment, and Health Care Services
Alabama Autism Assistance Program (AAAP) may use or disclose your protected health information (PHI) for treatment, payment, and health care service purposes with your written consent. To help clarify these terms, here are some definitions:
**PHI**–refers to information in your health record that could identify you.
**Treatment**-is when a health care professional provides, coordinates, or manages your health care and other services related to your health care.
**Payment**–is when AAAP obtains information about your healthcare benefits and eligibility and/or attempts to obtain and/or obtains reimbursement for your healthcare. Examples

of payment are when AAAP discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
**Health Care Operations**–is when AAAP discloses your PHI to your health care service plan (for example, your health insurer), or to other health care providers contracting with your plan, for administration of the plan, such as case management and care coordination.
**Use**–applies to activities within the AAAP office such as sharing, applying, utilizing, examining, and analyzing information that identifies you.
**Disclosure**–applies to activities outside of AAAP office such as releasing, transferring, or providing access to information about you to other parties.
**Authorization**– means written permission for specific uses or disclosure.

II. Uses and Disclosures Requiring Authorization
AAAP may use or disclose PHI for purposes outside of treatment, payment, and health care operations when an appropriate authorization is obtained. In those instances when AAAP is asked for information for purposes outside of treatment and payment operations, AAAP will obtain an authorization from you before releasing this information. AAAP will also need to obtain an authorization before releasing your therapy progress notes. Therapy progress notes are notes your therapist has made about your conversation, actions, observations, etc. during an individual, group, joint or family treatment session, which are kept separate from the rest of your medical records. These notes are given a greater degree of protection of PHI. You may revoke all such authorizations of PHI at any time; however, the revocation or modification is not effective until received by AAAP in writing.

III. Uses and Disclosures with Neither Consent nor Authorization
AAAP may use or disclose PHI without your consent or authorization in the following circumstances:
**Child Abuse**: If any AAAP Team Member knows or suspects that a child has or is being abused, abandoned, neglected, or neglected, the law requires that they report such knowledge or suspicion to the proper authorities according to the county and state you reside in.
**Adult and Domestic Abuse**: If any AAAP Team Member knows or suspects that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, they are required by law to immediately report such knowledge or suspicion to the local number located in the Rights of Our Clients section.
HIPAA PRIVACY AND SECURITY STANDARDS
**Health Oversight**: If a complaint is filed and later is open for investigation; a subpoena for confidential health information from certain parties may be requested and therefore shared.
**Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information regarding your diagnosis or treatment and the records thereof, such information is privileged under state law, and AAAP will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform AAAP that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
**Serious Threat to Health or Safety**: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, AAAP must communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.
IV. Patients' Rights and Therapist's Rights:
**Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, AAAP is not required to agree to a restriction you request. **Right to Received Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and alternative locations. For example, you may not want a family member to know you are in treatment. Upon request, AAAP will send your bills to another address.
**Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI of AAAP's treatment and billing records used to make decisions about you for as long as the PHI is maintained in the record. Upon your request, AAAP will discuss the details of the request process.
**Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record; however, AAAP may deny your request. On your request, AAAP will discuss with you the details of the amendment process.
**Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI. On your request, AAAP will discuss with you the details of the accounting process.
**Right to a Paper Copy:** You have the right to obtain a paper copy of this notice from AAAP upon request, even if you have agreed to receive this notice electronically. AAAP is required by law to maintain the privacy of PHI and to provide you with a notice of AAAP's legal duties and privacy practices with respect to PHI. AAAP reserves the right to change the privacy policies and practices described in these notices. Unless you are notified of such changes, however, we are required to abide by the terms currently in effect.
If AAAP revises privacy policies and practices, they will make their best effort to contact you with this information in person, by telephone, by email, or by mail. For this reason, it is important that you notify AAAP immediately of any address, telephone, or email changes.
**Exercising Your Rights**: You must submit a written request to exercise your rights under this Notice. Your request

should be mailed to:
Alabama Autism Assistance Program
Attention: Privacy Officer
300 Shadow Wood Park STE 100
Birmingham, AL 35244
**Notification of Breach**: In the event of a breach of the security of your PHI, we will provide you with a notification about the breach, including what steps we have taken in response to the breach and what you may do to reduce the risk of harm from the breach.

V. Complaints
If you believe your privacy rights have been violated, you can file a complaint with us by calling AAAP 205-733-0976 or by mailing the complaint to:
You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights.
If you have questions about this notice, disagree with a decision AAAP makes about access to your records, or have other concerns about your privacy rights, you may contact AAAP at 205-733-0976. You have specific rights under the privacy rule. AAAP will not retaliate against you for exercising your right to file a complaint.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
***Alabama Autism Assistance Program***

By signing below, you agree that you have received and reviewed or have been offered to review the Notice of Privacy Practices for Alabama Autism Assistance Program (AAAP). The Notice of Privacy Practices provides information on how AAAP uses and discloses protected health information. As provided in our Notice, the terms may change. If you would like to receive a revised copy, please call 205-733-0976.

_____
Client's Printed Name

_____ _____ _____
Client's Signature (or authorized representative) (Date) (Time)

_____ _____ _____
(Witness Signature) (Date) (Time)

**Alabama Autism Assistance Program/ The HANDS Program**
**RECORD OF RELEASE of INFORMATION**

Client Name:_____ Date of Birth (mm/dd/yy): _____/_____/_____

Address: _____ City: _____ St:_____ Zip:_____

* I authorize Alabama Autism Assistance Program/ The HANDS Program to use or disclose my health information as described below.
Type of Information: The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

_____ The entire record (all information) _____Therapy/Progress Notes _____ Business Office Files

_____Testing/Results _____ Assessments _____Treatment Plan _____ Other: Please Specify.

Recipient of Information: The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

* Unless I specify differently, this authorization will expire (insert date or event): _____
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Alabama Autism Assistance Program/The HANDS Program staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Client Name or Parent/Legal Guardian Name (Printed) Date

_____
Authorized Signature or Parent/Legal Guardian Relation to Patient

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**
**METHOD OF COMMUNICATION**

CLIENT NAME:_____ DATE OF BIRTH (mm/dd/yy): _____ /_____ /_____

I agree to allow Alabama Autism Assistance Program/The HANDS Program and staff to contact me using the following communication method(s) regarding personal health information, evaluation and treatment. I authorize/do not authorize Alabama Autism Assistance Program/The HANDS Program and staff to leave messages for me when I am unavailable as indicated below.

I authorize Alabama Autism Assistance Program/The HANDS Program and staff to discuss the client's personal health information with the individuals listed below. I understand that by leaving the spaces blank, I am indicating by choice that I do not want information shared with or released to anyone else.

By signing below, I hereby acknowledge that I have read and understand the information provided on this consent form. I understand the risk associated with the different methods of communication and consent to the communication outlined in this consent form.

_____ _____
Client Name or Parent/Legal Guardian Name (Printed) Date

_____
Authorized Signature or Parent/Legal Guardian Relation to Patient

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**
**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 the invoice. AAAP/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: If you are unable to keep your appointment, please call your therapist within 4 or more hours to reschedule or cancel to avoid a cancellation fee. Sessions canceled within an hour or less of the session time will be charged $40. If you do not show up to your appointment without letting your therapist know, you will be charged the full cost of the session. 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. Failure to provide timely payment will result in interruption in services until the invoice is paid in full. All accounts over 90 days past due will receive notice for discontinuation of services, and will be placed into collections processing. I understand that I am responsible for my bill. I hereby agree to pay in full, all amounts due for services rendered by AAAP/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. By signing below, I authorize AAAP/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 AAAP/The HANDS Program. I understand what I have read and agree to comply with the policies.
INSURANCE: As a courtesy, we will gladly verify your benefits and file your claims with your insurance company. You are responsible for any deductible, copays and/or coinsurance 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 the actual claim, and are solely based on your benefit plan.
We do not make any guarantees regarding what an insurance company will cover and/or amount they will pay.

Client Name:_____ Date: _____

Signature of Responsible Party:_____ Date: _____

PRINT Name of Responsible Party: _____

Hello parents and caregivers,

Thank you for completing the HANDS Application. We look forward to working with you and your family in the near future. In the meantime, we ask that you send over the following documents to ensure a smooth flow in transition from waitlist to services:

**-Picture of the front and back of insurance card**
**-Picture of the front and back of driver's license**
**-Diagnosis of autism**
**-Referral for ABA therapy**
**-Last well child visit with a neurological evaluation**
**-Cognitive/Developmental Evaluation**
**-IEP/BIP if applicable**

Excluding the diagnosis these documents will need to be within the last 5 years. Please let us know if you have any questions. You can send these documents in through the following methods:

**-Email:** info@thehandsprogram.org
**-Phone:** 205-733-0976
**-Fax:** 205-533-7910
**-Mail to:** 300 Shadow Wood Park, Suite 100
Birmingham, AL 35244

Thank you,
AAAP/The HANDS Program