DEMOGRAPHICS SHEET

Client Name ____

Address ____

City ______________________ **State** ______________________ **Zip** _____________________

Home Phone______________ **Cell Phone** _________________ **Work Phone** ________________

Date of Birth ________________ **Male** [ ] **Female** [ ] **Marital Status** _____________________

Insurance Information

Primary Insurance ____

Policy/ID number ____

Group Number ________________________ **Group Name** ______________________________

Subscriber/Guarantor __________________ **Subscriber Date of Birth** _____________________

Employer ____________________________ **Relationship to Patient** ______________________

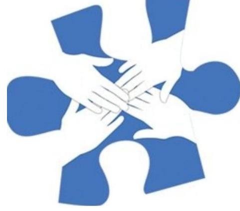
Secondary Insurance ____

Policy/ID number ____

Group Number ________________________ **Group Name** ______________________________

Subscriber/Guarantor ___________________ **Subscriber Date of Birth** ______________________

Employer _____________________________ **Relationship to Patient** _______________________



HANDS Behavioral Therapy
Enrollment Application

CONTACT INFORMATION

Date of Completion: ___/___/___ Person Completing: ___________________________

Child's Name:________________________ Age: ______ D.O.B. ___/___/___

Parent/Guardian's Names: ____

Parent/Guardian's Occupations: ____

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

Phone Number(s): ____

Address: ____

Email Address: ____

Emergency Contact Name and Number: __________________________________

Referred By: ____

MEDICAL INFORMATION

Diagnoses: ____

Date Diagnosed: ___________________ Diagnosing Physician: ______________________

Medications: ____

Special Diet: ____

Allergies: ____

CURRENT INTERVENTIONS

School: ________________________________ Grade: _____ Setting: _________________

Does your child receive Special Ed. Services? **Y N** If yes, amt. of resource time: ________

Does your child have a 1:1 aide? **Y N** If yes, % of day with aide: _____________________

Speech Therapy Services (therapist/agency): _____________________________________

Date Started: ___/___/___ Current Frequency of Services: ___________________________

Current Goals: ____

Occupational Therapy Services (therapist/agency)**:** ________________________________

Date Started: ___/___/___ Current Frequency of Services: ____________________________

Current Goals: ____

Behavior Therapy/ABA Services (therapist/agency): ________________________________

Date Started: ___/___/___ Current Frequency of Services: ____________________________

Current Goals: ____

Describe what concerns you have that prompted you to contact HANDS, LLC.

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/Babble
_________ Roll over
_________ Sit alone
_________ Single Words
_________ Speak phrases
_________ Speak Sentences
_________ Toilet Trained
_________ Crawl
_________ Stand alone
_________ Walk alone
_________ Feed self
_________ Dress self

How does your child communicate?

_____ Crying
_____ Sounds
_____ Pointing
_____ Words
_____ Phrases
_____ Sentences
_____ Sign Language
_____ PECS
_____ Eye Gaze
_____ Electronic Talking Device

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
______ Talking
______ Reading
______ Math

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

____
____
____
____

SOCIAL/LEISURE SKILLS

Does your child make eye contact when interacting with others?

Usually Sometimes (spontaneously) Sometimes (with prompting) Rarely

Does your child return greetings from peers/adults?

Usually Sometimes (spontaneously) Sometimes (with prompting) Rarely

Does your child initiate greetings with peers/adults?

Usually Sometimes (spontaneously) Sometimes (with prompting) Rarely

Does your child initiate play interactions with peers?

Usually Sometimes (spontaneously) Sometimes (with prompting) Rarely

Does your child seek attention from others when a significant event occurs in the environment? For example, if an airplane flies overhead, does your child look at you and point toward the plane of tell you to look at the plane?

Usually Sometimes (spontaneously) Sometimes (with prompting) Rarely

Does your child play with toys as designed?

Usually Sometimes (spontaneously) Sometimes (with prompting) Rarely

Does your child take turns or share toys with others?

Usually Sometimes (spontaneously) Sometimes (with prompting) Rarely

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 a teacher:student ratio of 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 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?

Right Left

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 the ground, touching others, etc.) that your child displays, estimate the number of times these behaviors happen (ex. 100 times/day, 10 times/week, etc.) and list a few examples of when the behaviors occur (ex. morning, non-preferred tasks, told no, etc.). Also, describe what strategies you have tried to manage the behaviors and whether these strategies have been successful or not.

Behavior	**Frequency**	**Setting events of 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? Check all that apply.

_____ Very active
_____ Sometimes active but can play quietly
_____ Not active
_____ Unusually happy
_____ Moody
_____ Demands attention
_____ Aggressive towards self or others

Please list three goals you would like your child to accomplish at HANDS, LLC.

____
____
____
____

Please list any other information that may be helpful while assessing or conducting therapy with your child (use the back if necessary).

____
____

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 unique needs.

Please include a copy of your insurance card and driver's license.

The Alabama Autism Assistance Program
The HANDS Program

FINANCIAL AGREEMENT

Payments:
Invoices for all services rendered will be mailed at the beginning of each month for the month prior. Please submit payment within ten days of receipt of invoice. HANDS accepts cash, checks, debit cards, and all major credit cards. There will be a $35 fee for returned checks.

Canceled Appointments:
If your child cannot attend a scheduled therapy session due to illness or any other reason, please contact your therapist at least 24 hours prior to the scheduled appointment in order to avoid being charged. Late cancellations (less than 8 hours notice) will be charged a $20.00 cancellation fee, and no shows will be billed for the full session.
*If your child is sick or has a fever, please do not bring him/her for therapy. Your child must be symptom free without medication for 24 hours before attending therapy.

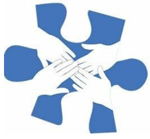
Past due accounts:
Any past due accounts will be charged a $25 late fee. Accounts over 30 days past due will be charged to the credit/debit card on file. All accounts over 90 days past due will receive notice for discontinuation of service and will be placed into collections processing.

I understand that I am responsible for my bill. I hereby agree to pay in full, all amounts due for services rendered by The HANDS Program, no later than thirty days from the date services are rendered unless other specific written arrangements are made. In the event of default in the 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 costs of collections or securing or attempting to collect or secure said indebtedness, including all reasonable attorney fees. By signing below, I authorize the HANDS Program to collect payment for any debt I may accrue.

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 _______________



The Alabama Autism Assistance Program
The HANDS Program

General Media Release Form

Date ___ /___ /___

1) I, the undersigned, hereby authorize AAAP/HANDS to photograph me, take video footage of me, and/or make electronic sound recordings of me (herein referred to as photographic or electronic reproductions).
2) I authorize the use of any such photographic or electronic reproductions of me for any purpose, including, but not limited to educational and other public media as may be deemed appropriate by AAAP/HANDS (I understand that I may be identifiable from such photographic or electronic reproduction).

Agreed and accepted by:

Print Name ______________________________________

Address ____

City, State, Zip ____________________________________

Phone ____

Signature & Date __________________________________

Parental Consent:

I certify that I am the parent or 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.

_____________________________________ Signature of Applicant's Parent/Guardian

_________________________ Date

_____________________________________ Address of Parent/Guardian (if different)

(_____)____________________ Phone Number (if different)

_____________________________________ City, State, Zip Code