ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS…

OFFICE INTAKE

A.T.S. must have this page filled out completely by a parent or legal guardian BEFORE any Evaluation can be initiated.

PATIENT'S NAME : ______________________________ DATE OF BIRTH : ____________________ SS #: ________________________

PARENT OR GUARDIAN'S NAME: ____________________________________

PRIMARY PHYSICIAN OR GROUP :____________________________________

PRIMARY INSURANCE COMPANY: ____

PRIMARY INSURED'S NAME ______________________________ DATE OF BIRTH : ___________________ SS #: ____________________

SECONDARY INSURANCE COMPANY: ____

SECONDARY INSURED'S NAME : ___________________________ DATE OF BIRTH : __________________ SS #: ____________________

IF INSURANCE IS TRICARE: STANDARD or PRIME (please circle one)

DOES THIS PATIENT HAVE INSURANCE THROUGH ANOTHER PARENT OR GUARDIAN? YES or NO (circle one)
IF YES, INSURANCE COMPANY NAME IS ________________________

PRIMARY INSURED'S NAME IS______________________DATE OF BIRTH : ___________________ SS #: ___________________

DOES THIS PATIENT HAVE THEIR OWN INSURANCE (example TennCare) ? YES or NO (circle one)
IF YES, INSURANCE COMPANY NAME IS ________________________

PRIMARY INSURED'S NAME IS______________________DATE OF BIRTH : ___________________ SS #: ___________________

DID YOU CALL YOUR INSURANCE COMPANY TO SEE IF THE SERVICES PROVIDED HERE ARE COVERED FOR THE PATIENT?
YES or NO (circle one)

FAILURE TO PROVIDE ALL INSURANCE INFORMATION WILL RESULT IN THE PARENT/GUARDIAN BEING RESPONSIBLE FOR ALL FEES ASSOCIATED WITH EVALUATIONS AND THERAPIES. (to show that you have read the following two statements, write your initials in the blank to the left)

_____ I UNDERSTAND I AM RESPONSIBLE FOR ANY BALANCE THE INSURANCE COMPANIES DO NOT PAY

_____ I WILL INFORM A.T.S. OF ANY CHANGES TO INSURANCE POLICIES, ADDITIONAL INSURANCE OR LOSS OF INSURANCE COVERAGE AS SOON AS CHANGES ARE MADE

PATIENT OR PATIENT'S PARENT OR GUARDIAN MUST PROVIDE ATS OFFICE WITH THE FOLLOWING:

- ☐ *COPY OF DRIVER'S LICENSE*
- ☐ *COPY OF INSURANCE CARD(s) (OR MILITARY ID)*

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Consent for Services

I, the undersigned, authorize Advanced Therapy Solutions, LLC to provide ABA Therapy, Behavioral Health, Occupational Therapy, Physical Therapy, Speech Therapy & Feeding Therapy services for me/my child. I also consent for the release of all medical, ABA, Behavioral Health, Occupational Therapy, Physical Therapy, Speech Therapy & Feeding Therapy information for the purposes of medical treatment, payment, and for regulatory agencies.

________________________________ ________________________________
Printed name of client Date

________________________________ ________________________________
Signature of client or legal guardian Relationship to client

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Authorization to Release Medical Information

I, the patient, parent, or legal guardian, authorize the release of information for the purpose of medical treatment, payment, for regulatory agencies, and care coordination for:

First MI Last Date

Street Address City State Zip

Releasing Agent	Receiving Agent
Organization	Advanced Therapy Solutions, LLC
Address	Address
City State Zip	City State Zip
Phone Fax	Phone Fax

Advanced Therapy Solutions may release the following medical information:

All ☐	History and Physical☐	Demographic Information☐
Evaluations☐	Test results☐	Behavioral Health Information☐
Therapeutic office notes☐	Discharge Summary☐	Verbal☐

Print name ____________________ Date ______

Sign name ____________________ Date ______

The therapists at Advanced Therapy Solutions LLC consult with parents in the waiting room & other open areas. If you are uncomfortable with this, we can arrange something different for you, but please notify staff in the front office as soon as possible.

Authorization may be revoked at any time per the discretion of the patient, parent or legal guardian of the above aforementioned by signing below:

Signature ____________________ Date ______

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Financial Policy

Thank you for choosing Advanced Therapy Solutions as your Speech, Occupational & Physical Therapy provider. We are committed to providing the best possible treatment for our patients. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require all patients or legally responsible individuals to read and sign prior to evaluation or treatment. All patients must also complete our Office Intake Information and Insurance Form before being evaluated or treated.

It is a courtesy of our office staff to file claims for our patients, but an insurance policy is a contract between the patient and the insurance company. We cannot guarantee payment of your claims. Reduction or rejection of insurance claims does not relieve your financial obligation.

Adult patients are responsible for full payment of service.

The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for payment at the time of service if required.

All co-pays, deductibles and co-insurances are due at the time of service.

Our office accepts: VISA, MASTERCARD, DISCOVER, CASH & DEBIT CARDS

I acknowledge responsibility for payment for all medical fees regardless of any insurance I may have to assist me in this responsibility. I assign all medical benefits payable to Advanced Therapy Solutions. I understand that I am responsible for full payment, unless I am under the coordination and care of services through Tennessee's Early Intervention System (TEIS), for all non-covered charges. If my insurance carrier does not pay the charges submitted by Advanced Therapy Solutions in a timely manner (within 90 days), I understand that I am responsible for full payment. Should I become delinquent on these bills, I give permission for information to be released to the appropriate credit reporting agencies. In the event that charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (or both), I will be responsible for all costs including, but not limited to, collection fees, attorney's fees, skip tracing costs and court costs. The amount I owe will not be less than 35% of total costs.

I have read, understand and agree to the above Financial Policy.

Patient or Responsible Party　　Date　　　　Co-Responsible Party　　Date

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

HEALTH AND ILLNESS POLICY

Advanced Therapy Solutions follows the Health Department's guidelines for the childcare program setting. A child is not to be brought to therapy if any of the following symptoms are observed in the past 24 hours.

*Fever and sore throat, rash, vomiting, diarrhea, earache, irritability, or confusion. Fever is defined as having a temperature of 100 degrees or higher taken under the arm, 101 degrees if taken orally, or 102 degrees if taken rectally.

*Diarrhea with runny, watery, or bloody stools.
*Vomiting two or more times in a 24 hour period.
*Body rash or bumps with fever.
*Sore throat with fever and swollen glands
*Severe coughing with redness or blue in the face or makes high-pitched whooping sound after coughing
*Eye discharge-where thick mucus or pus is draining from the eye, or pine eye, conjunctivitis (yellowish discharge from eyes)
*Yellowish skin or eyes
*Lice, scabies, or other parasitic infestation
*Difficult or rapid breathing
*Stiff neck
*Ring worms
*Discoloration of nasal drainage
*Irritable, continuously crying, or requires more attention than the therapist can provide.

In order to ensure the health and welfare of all the children at our facilities and to decrease the amount of illnesses,
YOUR CHILD SHOULD HAVE A NORMAL TEMPERATURE OF 98.6 FOR 24 HOURS BEFORE HE/SHE COMES TO THERAPY.

The therapist has the option to refuse services to a sick child.

Thank you for your cooperation. Our goal is to help your children and keep them healthy and safe.

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

ATTENDANCE POLICY

CANCELLATIONS:

• If you must cancel an appointment for a reason other than sudden illness, you must contact our office or let your therapist know 24 hours before your scheduled appointment

• If you are to cancel three scheduled therapy sessions for non-medical emergencies without giving adequate prior notification to your therapist, it will be at the discretion of Advanced Therapy Solutions whether or not to terminate services.

NO SHOWS:

• Failure to cancel or to appear during an appointment time is considered a "no show". A $15 fee will be assessed. Please contact our office immediately to discuss future appointments.

• If three (no shows(occur, the patient's appointment time will be

automatically offered to another patient waiting for services.

A NOTE FROM THE THERAPIST:

We expect for you to make every effort possible to attend your scheduled appointments. When we establish a plan of care for the patient, we base our goals on the patient having consistency. If the patient misses appointments, they will not meet their goals as quickly, and will have to be enrolled in therapy for a longer period of time. The success of our treatment sessions depends on consistency. In the event that you do have to cancel, we strongly encourage you to reschedule, even if it is with another therapist. We actually enjoy when another therapist sees one of our patients because it gives us another opinion of ideas for the patient. We are always in close communication with each other. Any other concerns you may have, please discuss this with your therapist.

I have read and understand the attendance policy of Advanced Therapy Solutions:

Signature____ **Date**_______________

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Notice of Privacy and Security Practices: Acknowledgement of Receipt

I, the undersigned, acknowledge that I understand Advanced Therapy Solutions Notice of Privacy & Security Practices. Our Notice of Privacy & Security Practices provides you with information about how we may use or disclose your protected health information (PHI). The Notice also explains how you can access, amend, and restrict your protected health information. We encourage you to read it in full. **It is available for you to read in full upon request or on our website (advancedtherapy.net).**

____
Printed name of client

____
Date

____
Signature of client or legal guardian

____
Relationship to client

ABA INITIAL ASSESSMENT QUESTIONNAIRE

I. GENERAL INFORMATION

Child's full name___________________________ DOB__________ Age_____ Sponsor ID# _____________

Current Address: ____

How long at this address? ____

Person providing information: ____

Relationship to child____

Who does child live with: □ both parents □ mother □ father □ other (specify) ___________________________

Biological father______________________ Occupation_____________ Years education: ________________

Father's home phone__________________ Work #_______________ Cell #__________________________

Biological mother_____________________ Occupation_____________ Years education: ________________

Mother's home phone __________________ Work #_______________ Cell #__________________________

If applicable: Guardian's name________________ Occupation ____________Years education____________

Guardian's home phone ________________ Work #_______________Cell # __________________________

Please list all people in child's immediate family:____

____

Name Relationship to child Age / Grade Living in house?____

____

Please list all other *non-family* members who live in household:____________________________________

____

Name Relationship to child/family How long has lived in household?__________________________________

____

Language(s) spoken at home ___________________________________

Primary Language at home____________________________________

Please list all locations (city, state) that your child has lived (use back of page, if needed):

1. Birthplace ____ Moved at age_____grade_________

____

2. ____ Moved at age_____grade__________

____

3. ____ Moved at age_____grade__________

____

4. ____ Moved at age______grade_________

____

Are biological parents of child currently: □ married □ separated □divorced □ never married

• If separated or divorced, who has *legal* custody? □ mother □ father □ other (specify): __________________

____

• If separated or divorced, how do you feel your child has adjusted to the separation/divorce?_____________

____

Are there other adults who have a ***significant*** part in raising your child? □Yes □No

If so, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.)_________________

____

Have there been any significant changes in the home over the *last few years*? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc)____

____

What do you feel are your child's…

Strengths____

Weaknesses ____

Briefly describe your concerns for your child.______________________________________

____

II. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Is your child: □ biological child □ adopted child □ foster child □ other: ______________________

Mother's age at birth? ________ Did mother receive routine medical prenatal care? □Yes □ No

Please specify any medications used during pregnancy and the reason used: __________________________

____

____

Pregnancy lasted ______________weeks / months Child's birth weight: ______pounds _____ounces

APGAR score …at 1 minute_____ …at 5 minutes_____ □ Unsure / Don't know

Did child go home from the hospital at the same time as the mother? □Yes □ No

If No, explain why:____

____

Please check the conditions below that describe the health of the child and mother during…

Mothers pregnancy	Child's Delivery	Child's Condition at Birth
□ No complications	□ Normal	□ Normal
□ Blackouts	□ Induced labor	□ Lack of oxygen
□ Falls	□ C-section	□ Breathing problem
□ Physical injury	□ Breech birth	□ Birth injury/defect
□ Excessive bleeding	□ Unusually long labor (>12 hours)	□ Jaundice
□ Hypertension	□ Premature # of weeks	□ Newborn ICU # of days
□ Diabetes	□ Overdue # of weeks	□ Other problem (specify)
□ Emotional stress	□ Other problem (specify)	
□ Toxemia		
□ Alcohol and/or drug use		
□ Use of tobacco		

B. Health

Describe the state of your child's current health: □ Excellent □ Good □ Fair □ Poor

Please list all medical conditions and Diagnosis: ____

Is your child currently taking any medication? □Yes □ No

If yes, please list medications and uses: ____

____

Has your child ever received psychological counseling? □Yes □ No

If so, by whom (professional/agency) and when: ____

____

Has your child ever participated in therapy services from a private entity? (i.e., speech, occupational, physical, vision therapy, etc)? □Yes □ No

If so, by whom (professional/agency) and when: ____

____

Has your child ever participated in ABA services from a private entity (i.e., private ABA, ABA in school, ABA in daycare, etc.)? □Yes □ No

If so, by whom (professional/agency) and when: ____

____

Has your child ever participated in an early intervention program? □Yes □ No

If so, by whom (professional/agency) and when: ____

____

If your child had any prior ABA services, why did services end? ________________________________

How effective were prior ABA services? ____

Has your child had any of the following? Please check all that apply.	Please describe and give details, dates, and/or age of onset
□ Serious Illnesses	
□ Head Injuries	
□ Seizures or convulsions	
□ Surgery/Hospitalization	
□ History of Ear Infections	
□ Allergies and/or Asthma	
□ Vision Problems	
□ Hearing Problems	
□ Frequent Nightmares and/or Bedwetting	
□ Other health problem	

Family History

Is there a ***family history*** for the following problems?	*Biological* family member with the history… (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc)
□ Learning Difficulties (reading, math, writing, spelling)	
□ Speech or Language problem (articulation, stuttering, etc.)	
□ Developmental Disorder (such as Autism, Asperger's disorder, etc.)	
□ Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
□ Intellectual Disability	
□ School Failure (failing grades, dropout, etc)	
□ Drug or Alcohol Addiction	

C. Development

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Held head up								
Responsive smile								
Rolled over								
Sat up without help								
Crawled								
Pulled to standing								
Walked alone								
Walked up Stairs								
Babbled-played with sounds								
Spoke first words								
Spoke short								

phrases (ex. “more milk”)								
Spoke in sentences (ex: “I want more milk”)								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								

Current Development

****We recognize that children are referred to us at various ages and for various reasons. Please complete this section to the best of your ability.**

In what way does your child communicate his/her needs? (pointing, crying, gestures, single words, phrases, sentences, etc.). ____

____

Do family members and familiar people understand what your child says? ______________________________

What percentage of the time is he/she understood? ____________________%

Do unfamiliar people understand what your child says? ____

What percentage of time is he/she understood? _________________%

Does your child appear to understand and follow directions as well as other children the same age? If not please explain: ____

Does your child respond to and answer questions as expected? If not, please explain: ___________________

____

Does your child turn to person speaking when his/her name is called? ________________________________

III. BEHAVIOR

A. Behavior in Infancy

During your child’s first *few years of life*, were any of the following present to *significant* degree?

- ☐ Did not enjoy cuddling
- ☐ Was not easily calmed by being held or being stroked
- ☐ Difficult to comfort
- ☐ Colicky
- ☐ Excessive irritability
- ☐ Diminished sleep
- ☐ Difficult nursing
- ☐ Poor eye contact
- ☐ Did not turn towards caregivers
- ☐ Did not respond to name
- ☐ Did not respond to speech of caregivers
- ☐ Fascination with certain objects

☐ Frequent head banging ☐ Constantly into everything

* Please describe all checked items ____

____

____

B. Current Behavior

☐ Activity Level – How active has your child? ________________________________

____

☐ Distractibility – How well does your child able to maintain focus or concentration, or pay attention to tasks?

____

____

☐ Adaptability - How well does your child able to deal with transition, change, or when denied his/her own way? ____

____

☐ Approach/Withdrawal – How well does your child able to respond to new things (i.e., new places, people, food, etc.)? ____

____

☐ Intensity – Whether happy/unhappy, how strong are your child's feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.? ________________________________

____

☐ Mood – What is your child's basic mood? Does he/she exhibit frequent or rapid changes in mood or temperament? ____

____

☐ Regularity – How predictable is your child's patterns of activity level, sleep, appetite, etc.? __________

____

List current problematic behaviors and give a brief description:

1. ____

____

2. ____

____

3. ____

____

4. ____

____

5. ____

____

Please explain any concerns you have about your child's behavior: ______________________________

Does your child have more difficulty than other children his/her age…

- ☐ Sitting still at meal time
- ☐ Paying attention when read to
- ☐ Throwing a ball
- ☐ Catching a ball
- ☐ Buttoning and zipping
- ☐ Holding a crayon or pencil
- ☐ Accidentally dropping things
- ☐ Staying focused on TV, movies, or video games
- ☐ Waiting for a turn to play
- ☐ Knowing left and right
- ☐ Acting without thinking
- ☐ Dressing self
- ☐ Tying shoe laces
- ☐ Accidentally knocking things over

C. Differential Behaviors

Please check below all behaviors or characteristics that fit your child over the past year:

- ☐ Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn
- ☐ Talks excessively, interrupts often, doesn't listen
- ☐ Low energy/fatigue
- ☐ Poor concentration
- ☐ Difficulty initiating tasks
- ☐ Difficulty completing tasks
- ☐ Difficulty following instructions
- ☐ Engages in impulsive behaviors (acts before thinking)
- ☐ Immature compared to peers
- ☐ Engages in physically dangerous activities
- ☐ Often argumentative with adults
- ☐ Often actively defiant to adult requests and rules
- ☐ Blames others for own mistakes
- ☐ Often angry or resentful
- ☐ Somatic complaints of not feeling well
- ☐ Excessive separation difficulties
- ☐ Easily frustrated
- ☐ Often depressed/irritable mood
- ☐ Often loses things, very disorganized compared to others his/her age.
- ☐ Shy
- ☐ Feeling of worthlessness or low self-esteem
- ☐ Withdrawn
- ☐ Overly anxious or fearful
- ☐ Sleeping too little/insomnia
- ☐ Sleeping to much
- ☐ Difficulty making decisions
- ☐ Cries easily
- ☐ Temper tantrums
- ☐ Rapid mood changes/mood swings
- ☐ Suicidal thoughts
- ☐ Excessive need for reassurance
- ☐ Poor appetite
- ☐ Overeats
- ☐ Explosive temper with minimal provocation

- ☐ Lies
- ☐ Steals
- ☐ Aggressive towards others
  - o Adults
  - o Peers
- ☐ Odd fascinations
- ☐ Unrealistic worry about futures events
- ☐ Substance abuse
  - o Drug
  - o Alcohol
  - o other

Please explain all checked items: ____
____
____
____
____
____
____
____
____

D. Home Behavior:

How often is each of the following settings a *problem* for your child?

While getting ready for school	☐ Rarely	☐ Sometimes	☐ Frequently
When eating at the dinner table	☐ Rarely	☐ Sometimes	☐ Frequently
When playing by him/herself	☐ Rarely	☐ Sometimes	☐ Frequently
When playing with siblings/other children	☐ Rarely	☐ Sometimes	☐ Frequently
When with a babysitter or daycare	☐ Rarely	☐ Sometimes	☐ Frequently
In public places (church, store)	☐ Rarely	☐ Sometimes	☐ Frequently
When in the car	☐ Rarely	☐ Sometimes	☐ Frequently
When told to do something he/she doesn't want to do	☐ Rarely	☐ Sometimes	☐ Frequently
During sit-down homework time	☐ Rarely	☐ Sometimes	☐ Frequently
When watching TV or playing video games	☐ Rarely	☐ Sometimes	☐ Frequently

How would you describe your child's personality at home?____
____

How does your child get along with brothers/sisters? ______________________________________

Which adult would your child prefer to talk with about a problem? ____________________________

Who is the *family member* with whom your child feels closest? ______________________

Who is primarily responsible for discipline at home? ______________________________________

What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, positive reinforcement, time-out, grounding, etc.)____
____

How does your child respond to discipline?____

List any responsibilities your child has at home: ____

Does your child do these regularly? __Yes __ No

Does your child need frequent reminders? __Yes __No

Indicate child's… Bed time? ____:____PM Wake time? ____:____ AM   Does child sleep well? __Yes __ No

How much time does your child typically spend on electronic media? ________________________________

Watching T V: _____hrs/day; Playing video/computer games: _____hrs/day; Other:____________ hrs/day

Have any family members expressed concerns about your child's behavior? __Yes __ No

Explain:____

____

E. Social Behavior:

How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does child associate w/ scholars or troublemakers?) ____

____

How does your child interact with children in the neighborhood?______________________________________

____

IV. Educational History

How does your child feel about school? ____

How motivated do you feel your child is to learn? ____

About how much time does your child spend on homework each night? __________________________

How much of a struggle is homework? □ Not a struggle □ Sometimes a struggle □ Often struggles

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)? □ Yes □ No

If yes, what services, when did they begin?____

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool/Daycare____

____

Elementary School____

____

Middle School____

____

High School ____

____