Newmeadow

Educating Young Children for Success

ABA INSURANCE SERVICES INTAKE PACKET

Please fill out this packet as completely as possible. This information will assist in the evaluation process. Please bring the completed packet with you the day of the initial evaluation.

NOTE: ALL INFORMATION PROVIDED IS KEPT CONFIDENTIAL

PERSONAL INFORMATION:

Person completing the Intake Packet: _____

Relation to patient: _____

Patient Information:

Child's Name: _____ DOB: _____

Nickname/Goes by: _____ SSN: _____

Address: _____

Home Phone: (_____) _____ Email: _____

School: _____ Grade: _____

Responsible Party Information:

Guarantor's Name: _____ DOB: _____

SSN: _____ Relation to patient: _____

Address if different than patient: _____

Home Phone: (_____) _____ Alternate Phone: (_____) _____

Employer: _____ Phone: (_____) _____

Emergency Contact Information:

Name: _____ Relation: _____

Home Phone: (_____) _____ Alternate Phone: (_____) _____

Insurance Information:

Primary Insurance Name: _____ Phone # on back of card: _____

Policy ID #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____

Relation to patient: _____

Secondary Insurance Name: _____ Phone # on back of card: _____

Policy ID #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____

Relation to patient: _____

Family History:

Parent's Name: _____ DOB: _____

Place of Employment: _____ Phone: (_____) _____

Occupation: _____ Highest Grade Completed: _____

Parent's Name: _____ DOB: _____

Place of Employment: _____ Phone: (_____) _____

Occupation: _____ Highest Grade Completed: _____

If parents do not live together, describe custody arrangements: _____

_____

Child is our: Biological _____ Adopted _____ Foster Child_____

Siblings:

Name	Age	M/F	Speech/Hearing, or Medical Conditions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Adults Whom Reside In The Household:

Name Relationship Type of Work

_____

_____

_____

Describe any medical, social or educational difficulties of any direct family member._____

_____

Who referred you to our agency?_____

Pregnancy/Birth History:

Did mother have any of the following during the pregnancy?

Bleeding _____	Virus Infection _____	Heart Condition _____
Swelling _____	Convulsions _____	Low Blood Pressure _____
Diabetes _____	RH Negative _____	High Blood Pressure _____
Asthma _____	Anesthesia _____	Thyroid Condition _____
Rubella _____	Surgeries _____	Alcohol Consumption _____
X-Ray _____	Smoking _____	Excessive Weight Gain/Loss _____
Accident _____	Kidney Disease _____	Toxemia _____

If yes, provide additional information: Which week/month of gestation? Was hospitalization necessary? _____

_____

Did mother take any medications during the pregnancy? If yes, which medications? _____

_____

What was the length of the pregnancy? _____

What was the length of hard labor? _____

Type of delivery (circle one):

Vertex (head presentation) Breech Cesarean Dry Other

Were there any unusual problems at birth? _____ If so, describe: _____

_____

Birth Weight: _____ Apgar score at 1 minute: _____ at 5 minutes: _____

Were there any health problems during the first two weeks of infant life?

Jaundice _____ Oxygen _____ Feeding Difficulty _____

Blueness _____ Convulsions _____ Breathing Difficulty _____

Hemorrhage _____ Transfusions _____ Incubator or Isolate _____

Tube Fed _____

For how long: _____

Was the first cry: strong _____ weak _____ high _____

Were intravenous or intramuscular fluids required? _____

How long did the child remain in the hospital? _____ Mother? _____

Is there any additional information regarding mother or baby during pregnancy and delivery that would help us to evaluate the child? _____

_____

Medical History:

Primary Care Physician: _____ Date of Last Visit: _____

Address: _____ Office Phone: _____

Medical Issues: _____

Allergies: _____

Current Medications (Include dosage & length of usage): _____

_____

Has the child had any of the following illnesses, surgeries, or injuries? If yes, please note at what age and the severity.

Whooping cough _____ Ear Infections _____

Mumps _____ Draining Ears _____

Scarlet Fever _____ PE Tubes Inserted _____

Measles _____ Tonsillectomy _____

Chicken Pox _____ Adenoidectomy _____

Pneumonia _____ Allergies _____

Diphtheria _____ Epilepsy _____

Croup _____ Encephalitis _____

Influenza _____ Typhoid _____

Headaches _____ Tonsillitis _____

Sinus problems _____ Chronic Colds _____

Meningitis _____ Head Injury _____

Rickets _____ Mastoidectomy _____

Rheumatic Fever _____ Asthma _____

Polio _____ Dental problems _____

Please describe any other operations or medical conditions your child has had that are not listed above: _____

_____

Pediatrician Name: _____ Office Phone: (_____) _____

List all doctors the child sees routinely: _____

_____

List all current medications your child is currently taking, both prescription and over the counter:

_____

Does your child have any seizure conditions? _____ Under what conditions? _____

_____

Is there any additional medical information that you feel would help with evaluating the child?

_____

Developmental History:

Has your child ever had ABA, speech/language, occupational therapy, or physical therapy in the past? Yes / No

If so, what type of therapy and when? _____

Where was therapy received? _____

Reason(s) for therapy: _____ Goals achieved? Yes / No

What is the primary language spoken in the home? _____

Are there any additional languages spoken in the home? _____

At what age did your child say his/her first word? _____

At what age did he/she use 2-word phrases? _____

At what age did he/she use sentences? _____

Has speech/language ever seemed to stop or decrease for a period of time? _____

If so, please describe: _____

How well can the child be understood by immediate family? _____

How well can the child be understood by others? _____

Which ONE does your child use most often? (circle one)

Sentences Phrases One or two words Sounds Gestures

Do you question your child's ability to understand directions and/or conversations? _____

If so, why? _____

Does your child hesitate, "get stuck", repeat, or stutter on sounds or words? _____

If so, describe: _____

Can your child read? _____ At what age did he/she begin reading? _____

Does your child's voice sound hoarse? _____ Low-Pitched? _____ Nasal? _____

Do you think your child hears adequately? _____

Do you think his/her hearing ability varies from day to day? _____

Has your child's hearing been checked recently? _____ What were the results? _____

_____

<u>Note the ages that the following occurred</u>:

Hold head erect	_____	Reach for Objects	_____	Toilet Trained	_____
Follow object with eyes	_____	Feed self with spoon	_____	Stand Alone	_____
Roll from back to stomach	_____	Sit unsupported	_____	Crawl	_____

Is there any additional developmental information that you feel would help with evaluating the child? _____

_____

HOME BEHAVIOR

All children exhibit, to some degree, the kinds of behavior listed below. Check the degree to which you believe your child exhibits each behavior when you compare your child to other children of the same age.

	HIGH	AVERAGE	LOW
Activity level	_____		
Frequency of temper outbursts	_____		
Frequency of physical aggression	_____		
Awareness of danger	_____		

	GOOD	POOR
Ability to learn from experience	_____	
Memory	_____	
Attention span	_____	
Self control	_____	

Describe any recent changes in your family (i.e. moving, separation, divorce, death,new baby). _____

_____

School Age History:

Preschool: _____ Age level/Teacher: _____

School: _____ Grade/Teacher: _____

Describe your child's typical grades / reports from the school: _____

_____

What concerns do you or the school have regarding school performance? _____

_____

Regarding attention/concentration? _____

Regarding work habits? _____

Regarding behavior? _____

Does your child receive special education services at school? Yes / No

What services are received? _____

Does your child have an IEP? Yes / No What is the date of the last IEP? _____

Is there any additional school related information that you feel would help with evaluating the child?

_____

_____

EATING/SLEEPING

Describe any sleep difficulties._____

Associated Services:

Intelligence testing: Yes / No Date: _____ Where: _____

Results: _____

Neurologic testing: Yes / No Date: _____ Where: _____

Results: _____

Psychological testing: Yes / No Date: _____ Where: _____

Results: _____

Physical Therapy evaluation: Yes / No Date: _____

Where: _____

Result: _____

Occupational Therapy evaluation: Yes / No Date: _____

Where: _____

Results: _____

Speech/Language Therapy evaluation: Yes / No Date: _____

Where: _____

Results: _____

****Please submit copies of any evaluation reports available with this packet****

Additional Background Information:

Describe your main concerns: _____

_____

_____

_____

When were concerns first noticed? _____ By whom? _____

What changes in your child's development and/or behavior have you noticed since that time? _____

_____

_____

_____

_____

List the people/organizations that you have consulted about the concerns:

Date Name / Address Outcome

_____ _____ - _____

_____ _____ - _____

_____ _____ - _____

AREAS OF CONCERN

_____ Difficulty swallowing

_____ Mouthing objects inappropriately

_____ Excessive drooling

_____ Biting, pinching, etc.

_____ Uses only 1-2 words

_____ Refusal to obey

_____ Echolalia

_____ Stuttering

_____Poor sentence structure

_____ Difficulty answering questions

_____ Difficulty chewing food

_____ Picky eater

_____ Inappropriate toy play

_____ Does not understand simple directions

_____ Difficulty sleeping

_____ Runs from parents, teachers, etc.

_____ Distractibility

_____ Poor/inappropriate eye contact

_____ Pronoun misuse

_____ Poor social interaction

_____ Numerous ear infections

_____ Misarticulating of words

_____ Seizure activity

_____ Impulsiveness

_____ Difficulty with change

_____ Dislikes being touched

_____ Places self in dangerous situations

_____ Clumsy, trips often

_____ Weakness in arms, legs, trunk

_____ Poor balance

_____ Unable to catch tossed ball

_____ Toe Walks

_____ Spins inappropriately

_____ Poor handwriting

_____ Poor hygiene

_____ Uses one hand more than other hand

_____ Strong gag reflex

_____ Difficulty climbing stairs

_____ Uncoordinated running pattern

_____ Sleeping difficulties

_____ Delay in sitting up

_____ No verbal language

_____ Bedwetting

_____ Thumb sucking

_____ Fixates on television/videos

_____ Dislikes malls, shopping centers, etc.

_____ Delay in pulling up, crawling

_____ Poor eye-hand coordination

_____ Unable to ride bicycle

_____ Fear of swings, playground equipment

_____ Increased muscle tone in arms, legs

_____ Lines up objects

_____ Weak hand muscles

_____ Unable to dress/undress self

_____ Unable to skip or hop on one foot

_____ Cannot feed self independently

_____ Intolerant to textures

_____ Hums to self

_____ Stimming activity/hand flapping

Please provide any additional concerns or information that you feel may be important regarding your child:

_____

_____

_____

_____

Name of person completing form (print): _____ Date Completed: _____

Signature of person completing form: _____

Newmeadow Student Diagnosis Information

Please complete this form and return to school as soon as possible. If not applicable please fill in name, date of birth, and check not applicable.

Name: _____

Date of Birth: _____

If not applicable, please check here ____.

Does your child have a diagnosis of autism? _____

If yes, what was the date of diagnosis? _____

If yes, who diagnosed your child? _____

Does your child currently receive ABA therapy in the home? _____

If yes, who provides the therapy? _____

_____

Does your child have any other diagnoses? _____

If yes, please indicate the diagnosis below.

_____

_____

_____

CANCELLATION & NO SHOW POLICY

All sessions are by appointment only and scheduled with a specific therapist. It is the family's responsibility to attend all scheduled appointments.

Should an appointment need to be cancelled, a 24-hour notification is appreciated whenever possible. All cancellations MUST be made by 9:00 a.m. the day of your child's therapy session to the front desk at (518) 899-9235 or the appointment will be considered a NO SHOW.

Please note that texting or utilization of any social media to notify the staff of Newmeadow, Inc. is not considered a formal cancellation. The front desk MUST be notified

If prior notification is not received in a timely manner as stated above, a NO SHOW fee will be billed to the responsible party. These fees CANNOT be billed to the insurance provider and are due prior to the next scheduled appointment. Failure to pay NO SHOW fees will result in your child being removed from the schedule.

The No Show Fee is $35.00 per missed appointment.

If a break in therapy lasting longer than 2 weeks occurs, your child may be removed from the schedule, unless prior arrangements have been made. It is the parent's responsibility to make necessary arrangements and to notify the office of any scheduling conflicts.

If 75% or more scheduled therapy sessions are not kept within each calendar month, your child may be removed from the schedule.

Therapy sessions are scheduled back to back. This makes timeliness at the start and end of each session very important. If two or more No Shows, late starts, or early end times occur within a calendar month, your child may be removed from the schedule.

By my signature below, I acknowledge that I have read the terms outlined in the Cancellation and No Show Policy, and agree to honor the terms of this policy.

Child's Name: _____ DOB: _____

Responsible Party Signature: _____

Responsible Party Printed Name: _____

Date Signed: _____

ALLERGY NOTIFICATION

From time to time your child's therapist may utilize examination gloves and various foods in the course of therapy to assess or stimulate certain speech-related behaviors. We are aware of the fact that some children are allergic to the materials used in examination gloves and may be on specialized diets or have good allergies. Please read the following lists carefully and indicate any allergies you know your child has. Please list any other known allergies in the space below. This information will be noted in a prominent place on your child's chart. Please keep your child's therapist informed of any allergic reactions, which are identified in your child over the course of his/her therapy program. Your child's health and safety are of the utmost importance to us.

The following are some of the foods and substances commonly used in therapy. Please circle any that your child is allergic to OR any which are not a part of your child's special diet:

Goldfish Crackers	Latex
Chewy Sweet Tarts	Chips (Lays, Doritos, Fritos)
Pretzels	Chocolate M&M's
Starbursts	Gummy Worms
Mini Oreos	Skittles
Juice	Applesauce
Raisins	Pixie Sticks
Dried cereal (Cheerios, Fruit Loops)	Hard Candy (lollipops)

Please list ANY other known allergies: _____

_____

If your child has no known allergies, please write "NO KNOWN ALLERGIES" in the blank below before signing this form:

_____

I have provided the information above to the best of my knowledge at the request of Newmeadow, Inc. and my child's therapist. I agree to inform Newmeadow, Inc. and my child's therapist of any change in the status of the above information.

Child's Name: _____

Responsible Party: _____

Today's Date: _____

AUTHORIZED PERSON(S)

Child's Name: _____ DOB: _____

As the parent/guardian of the child listed above, I authorize discussions regarding therapy sessions, progress, treatment plans and scheduling for my child to be held: (Please Initial One)

_____ by phone _____ by email _____ In a therapy room or private location only

As the parent/guardian of the child listed above, I hereby authorize the representatives at Newmeadow, Inc. to discuss any information regarding therapy sessions, progress, treatment plans, and scheduling of my child with the following person(s).

AUTHORIZED PERSON(S)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

CONSENT FOR SECURE/RELEASE OF INFORMATION

Child's Name: _____ DOB: _____

Address: _____

I/We hereby authorize and request Newmeadow, Inc. to secure and/or release medical, social, educational, and other clinical information regarding the patient named above. I/We understand that this authorization may be revoked in writing at any time. Otherwise this consent automatically expires two years from the date of signature. This authorization applies only to the following individuals/institutions: If not completed, no information will be released from our office.

Primary Care Physician: _____

Address: _____

Other: _____

Address: _____

I/We give permission for the therapist and/or staff at Newmeadow, Inc. to disclose/request information regarding scheduling of school based appointments, therapy, school performance, and/or any information deemed relevant to academic and therapy success. Information will not be disclosed to anyone not specifically listed below.

School Name: _____

Address: _____

Other: _____

Address: _____

I/We give permission for Newmeadow, Inc. to communicate via email, information, i.e. evaluations, therapy updates, and/or other clinical information regarding the patient listed above. Information will not be disclosed to anyone no specifically listed below.

Email Address: _____

Email Address: _____

I hereby further direct that a copy of this authorization shall be deemed to be as valid as the original for all purpose authorized herin.

Signature: _____ Date: _____

Relationship (if person named above is a minor): _____

Witness signature: _____

NEWMEADOW

RELEASE OF INFORMATION

CHILD'S NAME: _____

CHILD'S DOB: _____

I hereby give permission for Newmeadow to exchange information with:

X	**School District:**	_____
X	**County:**	_____
X	**Physician:**	_____
X	**Insurance Company:**	_____
	Service Coordinator:	_____

The information released will include, but not be limited to, the following when appropriate. The documents listed below are necessary for initial approval of services.

Developmental Assessment
Supplemental Evaluations
Draft Individual Education Program (IEP)
Developmental/Social Questionnaire
Health Examination Form

_____

PARENT/GUARDIAN SIGNATURE

_____

DATE

23 Sitterly Rd. ● Clifton Park, NY 12065 ● Tel 518.899.9235 ● Fax 518.899.9315
www.newmeadow.org

AUTHORIZATION TO EXCHANGE INFORMATION VIA SMS TEXT MESSAGE

I, _____, consent to have confidential and protected health information sent and received via text message. I will ensure that I keep Newmeadow, Inc. informed of my up to date mobile number at all times, or if the number is no longer in my possession. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor and/or dependents. Text message charges from my mobile phone provider may apply.

Name of Child: _____

Account Guarantor's Name (owner of phone): _____

Account Guarantor's Mobile Number: (_____) _____ - _____

Cell Phone Provider (i.e. Verizon, Sprint): _____

Please fill out below if there is a second mobile phone to be used:

Account Guarantor's Name (owner of phone): _____

Account Guarantor's Mobile Number: (_____) _____ - _____

Cell Phone Provider (i.e. Verizon, Sprint): _____

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services. I understand that this authorization can only be revoked in writing. I fully understand that text messaging is not a secure form of communication, and texts carry the risk of being intercepted by an unauthorized party. I hold Newmeadow, Inc. harmless in the event that a text carrying my child's protected health information is compromised by an unauthorized party.

_____ _____

Parent/Legal Guardian Signature Date

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Educating Young Children for Success

23 Sitterly Rd. ● Clifton Park, NY 12065 ● Tel 518.899.9235 ● Fax 518.899.9315
www.newmeadow.org

PARENTAL RELEASE & CONSENT TO USE OF PHOTOGRAPHS & VIDEOS

PHOTOGRAPHS

I, _____, grant permission to Newmeadow, Inc. to use photographs
(Parent/caregiver's name)

taken of my child _____, for use in: (please check below)
(Child's name)

_____ Newmeadow, Inc.'s newsletters, brochures, flyers, display boards and/or website

_____ Pictures on the wall in the ABA lobby

_____ Pictures in PowerPoint presentations used for staff training purposes (internal use)

VIDEOS

I, _____, grant permission to Newmeadow, Inc. to use videos of my child
(Parent/caregiver's name)

_____ during their therapy session, for use in: (please check below)
(Child's name)

_____ Staff training (internal use only)

_____ Staff training and Public trainings

_____ Website use

I hereby agree to release and hold harmless Newmeadow, Inc. and its employees from and against any claims, damages, or liability arising from or related to the use of the photographs and videos, including but not limited to any distortion, blurring, alteration, either intentionally or otherwise, that may occur or be produced in processing the photographs and/or videos.

_____ _____
Parent Signature Date

INSURANCE/CREDIT POLICY

Charges for services through our agency are due and payable at the time services are rendered. In the event billing arrangements are agreed upon, a statement will be mailed to you with payment due upon receipt. The client is responsible for payment regardless of the status of insurance claims.

When insurance claims go over 30 days without payment, the client must either suspend therapy until claims are paid to current status or continue therapy on a cash basis at the time services are provided. If the insurance company reimburses for claims already paid by the client, a refund check will be promptly issued to the client. Once all claims are paid to 30 days or less, the client will no longer be required to make cash payments, other than customary co-pays and deductibles, when applicable, at the time of therapy.

Except when hardship warrants otherwise, accounts 90 days past due are referred for collection. If you are involved in a liability claim, the above stated policies apply. We are unable to wait for settlement by the involved parties.

I have read and understand the above stated credit policy. I authorize Newmeadow, Inc. to bill my insurance provider on my or my dependent's behalf. I accept ultimate responsibility for my account and the amount due for services rendered. I will do everything possible to assist in collecting from my insurance carrier, if applicable.

_____ _____

Child's Name DOB

_____ _____

Responsible Party Signature Date

_____

Responsible Party Printed Name

AUTHORIZATION FOR AUTOMATIC HEALTH CARE PAYMENT BY CREDIT CARD

I authorize Newmeadow, Inc. to keep my signature on file and to charge my account for charges that are deemed Patient Responsibility.

This authorization extends to all recurring charges, co-payments, or deductibles incurred at the time of service unless another method of payent is provided at the time of service.

This authorization also applies to any missed appointments as described in the cancellation and No Show Policy. If the applicable fee cannot be paid by other means prior to the next scheduled appointment, your credit card on file will be charged the appropriate amount per stated policy.

This authorization shall be valid for one year, or until services are concluded, or with written notice to Newmeadow, Inc.

Patient's Name: _____

Cardholder's Name: _____

Cardholder's Billing Address: _____

_____

Credit Card Account Number: _____

3-Digit CVC (back of card): _____

Expiration Date: _____

Signature of Cardholder: _____

Date Signed: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

I have received a copy of the Notice of Privacy Practices; as well as Patient Rights and Responsibilities.

Signature of Responsible Party: _____

Printed Name of Responsible Party: _____

Date Signed: _____