Soaring on Hope

PEDIATRIC THERAPY CENTER

Consent for Care and Treatment

Client's Name: _____
(Please print)

Medicaid ID *(if applicable)* _____

I, _____ **(print name of parent/legal guardian)** hereby authorize *Soaring on Hope, LLC,* to screen or evaluate, as well as provide any subsequent treatment based on the screening or evaluation results for the child named above for the following services:

_____ Speech & Language Therapy

_____ Occupational Therapy

_____ Physical Therapy

_____ ABA Therapy

Parent/Guardian Signature: _____ Date: _____

Relationship to Client: _____

Group Representative Signature: _____ Date: _____

SOH PEDIATRIC THERAPY CENTER

APPLIED BEHAVIOR ANALYSIS IN-TAKE
-CONFIDENTIAL-

Please complete this intake questionnaire regarding your child. Feel free to add any additional information or attach additional reports that you think may helpful for us in getting to know your child. Spectrum of Hope views all of the information that you provide us with as strictly confidential. This information is helpful for us in developing an initial understanding of your child's needs and provides critical information for us to discuss with your insurance company to get authorization for services.

Today's Date: / /

GENERAL INFORMATION

Name of Person Completing this Form:

Relationship to Child/Adolescent:

Legal Name of Child/Adolescent:

Child/Adolescent's Date of Birth: / / Age:

How did you hear of our ABA agency?

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian 1 Name (First and Last Name):

Parent/Guardian 2 Name (First and Last Name):

Home Address:

Home Telephone: ( ) -

Parent/Guardian 1 Employer: Cell Phone: ( ) -

Parent/Guardian 1 Cell Phone: ( ) - Email: _____

Parent/Guardian 2 Employer: Cell Phone: ( ) -

Parent/Guardian 2 Cell Phone: ( ) - Email: _____

MEDICAL INFORMATION

Name of Physician:

Physician Address:

,

Physician Phone Number: ( ) - -

Child/Adolescent's Current Height: ft. in. Weight: lbs.

Which hand does your child/adolescent show dominance? ☐ Left ☐ Right ☐ No preference

Does your child/adolescent have any current health conditions, including infectious diseases?
☐ Yes ☐ No
* If yes, please explain below.

Please also provide the following:

Known Medical Conditions	Dates and Providers of Previous Treatment	Current Treating Clinicians	Current Therapeutic Interventions and Responses

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child/adolescent has had.

Does your child/adolescent have any vision problems? ☐ Yes ☐ No
* If yes, please explain below and if there are any treatments currently being used for correction.

Does your child/adolescent have any hearing problems? ☐ Yes ☐ No
* If yes, please explain below and if there are any treatments currently being used for correction.

Does your child/adolescent have a history of seizures? ☐ Yes ☐ No
* If yes, please describe the types of seizures and current treatment.

Is your child/adolescent currently taking any medications? ☐ Yes ☐ No

* If yes, please provide the following information:

Name of Medication	Amount	How often is the medication taken?	Prescribed for?	When is the medication taken?	Please state any reactions or side effects your child/adolescent experiences from the medication.

Does your child/adolescent have any allergies to medications? ☐ Yes ☐ No

* If yes, please describe, including any adverse reactions:

Does your child/adolescent have any other allergies (seasonal, food, etc.)? ☐ Yes ☐ No

* If yes, please describe, including any adverse reactions and if any epi pen is needed:

Does your child/adolescent currently have a diagnosis? ☐ Yes ☐ No

* If yes, please provide the following information:

Diagnosis	Diagnosing Physician	Date Diagnosed	Diagnosis Code

Please note that the diagnosis information is required for insurance coverage. By having this information, it assists us when speaking with your insurance company to get authorization for services and providing you with invoices for reimbursement through insurance.

CURRENT/PREVIOUS THERAPY PROVIDER INFORMATION

Please provide us with information regarding the following types of current or previous therapy providers and copies of any recent evaluations that indicate dates of previous treatment and therapeutic interventions and responses.

Does your child/adolescent currently receive behavioral services with another provider?
☐ Yes (Please provide information below.)
☐ No

Name of **Behavioral Provider**:

How does your child communicate at home? At school? In the community?

_____

_____

_____

Does your child/adolescent currently receive speech therapy services?
☐ Yes (Please provide information below.)
☐ No

Name of **Speech Therapy Provider**:

Describe any concerns you may have regarding your child's fine/gross motor skills:

_____

_____

_____

Does your child/adolescent currently receive occupational therapy services?
☐ Yes (Please provide information below.)
☐ No

Name of **Occupational Therapy Provider**:

Does your child/adolescent currently receive physical therapy services?
☐ Yes (Please provide information below.)
☐ No
Name of **Physical Therapy Provider**:

Does your child/adolescent currently receive psychiatric services?
☐ Yes (Please provide information below.)
☐ No

Does your child/adolescent currently receive any other services?
☐ Yes (Please provide information below.)
☐ No

Name of **Other Provider**:

EDUCATIONAL HISTORY

Please list all schools your child/adolescent has attended in order starting with the most current school.

Name of School	School System	Year(s)	Grade	Special Education Services
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Is your child/adolescent currently classified for special education services? ☐ Yes ☐ No
Does your child/adolescent currently have an IEP or BIP in place? ☐ Yes ☐ No

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FAMILY BACKGROUND

Does either parent/guardian's job require him/her to be away from home for long hours or extended periods of time that might prevent them from being involved in ABA services and parent training?
☐ Yes ☐ No

* If yes, which parent/guardian and for how long?

Who will be involved in parent/caregiver training for ABA services?

Marital Status:

☐ Married
☐ Civil Union
☐ Remarried
☐ Divorced
☐ Separated
☐ Widowed
☐ Single
☐ Cohabitants

* If divorced, who has legal custody? Is it full or joint custody?

Are there siblings? ☐ Yes ☐ No

* If yes, please provide the following information:

	Name	Age	Relationship	Living in Home?	School	Grade
1.				☐ Yes ☐ No		

2.				☐ Yes ☐ No		
3.				☐ Yes ☐ No		

Please indicate and describe whether any of the siblings have any special needs, diagnoses, or concerns.

Are you also interested in seeking services for any of the siblings with special needs?

☐ Yes ☐ No ☐ Not applicable

*If yes, you will need to complete a new intake packet for that child.

Are there any other individuals residing in the house or that play a significant role on how this child is raised?

☐ Yes ☐ No

* If yes, please identify who else is involved in raising the child and their relationship to the child.

SLEEP

Describe child's sleep schedule:

Describe typical bedtime routine:

PSYCHOLOGICAL HISTORY

Please indicate below whether or not there is a history of the following in your immediate family or in either biological parent's extended family.

Yes	No	
☐	☐	Autism Spectrum Disorders
☐	☐	Learning Problems/Disabilities
☐	☐	ADD/ADHD-Attention Problems
☐	☐	Clinical Depression
☐	☐	Bipolar Disorder
☐	☐	Behavior Problems in School
☐	☐	Anxiety Disorders (e.g., OCD, etc.)
☐	☐	Intellectual Disability
☐	☐	Psychosis/Schizophrenia
☐	☐	Substance Abuse/Dependence
☐	☐	Other Mental Health Concerns (Please specify:)

If yes, please indicate who in the family currently has or has had these diagnoses:

Has your child/adolescent had an outside psychological or psychiatric evaluation? ☐ Yes ☐ No

Has your child/adolescent ever been hospitalized for a psychiatric condition? ☐ Yes ☐ No

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child/adolescent.

BIRTH AND DEVELOPMENTAL HISTORY

Did the birth mother receive regular prenatal care? ☐ Yes ☐ No

Were there any complications with the pregnancy? ☐ Yes ☐ No
* If yes, please describe the complications below and treatment details.

Was birth at full term? ☐ Yes ☐ No
* If no, please provide details.

What was the type of delivery? ☐ Spontaneous ☐ Induced ☐ Vaginal ☐ C-Section

Were there any complications during delivery? ☐ Yes ☐ No
* If yes, please describe the complications below and treatment details.

What was your child/adolescent's birth weight? lbs. oz.

Were there any concerns at birth? ☐ Yes ☐ No
* If yes, please describe the concerns and treatment details.

Were there any developmental milestones that your child was delayed in or did not achieve?
☐ Yes ☐ No
* If yes, please identify those milestones below.

What concerns/delays brought you to seek out an Autism diagnosis?

CURRENT BEHAVIORAL CONCERNS

Please indicate if your child/adolescent engages in any of the following behaviors (check all that apply):

- ☐ Aggression (specify below)
  - ☐ Hitting (e.g., punch, slap, etc.)
  - ☐ Kicking
  - ☐ Biting
  - ☐ Pinching
  - ☐ Head-butting
  - ☐ Scratching
  - ☐ Spitting
  - ☐ Other (Please specify):
- ☐ Self-Injurious Behavior (specify below)
  - ☐ Hitting self with hands or fists (Where on body?:)
  - ☐ Kicking self (Where on body?:)
  - ☐ Biting self (Where on body?:)
  - ☐ Head-butting walls, windows, etc.
  - ☐ Pulling teeth
  - ☐ Scratching skin
  - ☐ Cutting/burning
  - ☐ Other (Please specify):
- ☐ Property Destruction (describe:)
- ☐ Eloping (i.e., running out of a building, room, vehicle, etc.)

- ☐ Sensory issues (describe:)
- ☐ Sexualized behaviors (describe:)

- ☐ Self-urinating/defecating
- ☐ Fecal smearing
- ☐ Rectal digging
- ☐ Difficulty with toileting
- ☐ Defiance or problems with authority
- ☐ Problems with eating
- ☐ Tantrums
- ☐ Screaming/yelling
- ☐ Vocalizations
- ☐ Repetitive behaviors
- ☐ Other (Please specify):

Additionally, please indicate if your child is experiencing any of the following (check all that apply)?

- ☐ Isolated socially from peers
- ☐ Difficulty making friends
- ☐ Problems keeping friends
- ☐ Sleep problems (describe:)
- ☐ Bedwetting
- ☐ Fire setting
- ☐ Anxiety
- ☐ Sadness or depression
- ☐ Hallucinations
- ☐ Delusions
- ☐ Suicidal ideation/attempts
- ☐ Legal situations
- ☐ History of physical abuse
- ☐ History of sexual abuse
- ☐ Alcohol use/abuse
- ☐ Drug use/abuse including nicotine and/or illegal drugs (list drugs:)
- ☐ Difficulty concentrating

Are there any current or past relevant legal issues pending with your child/adolescent?
☐ Yes ☐ No * If yes, please describe below.

DISCIPLINE INFORMATION

Please rate what percentage of discipline is handled by each of the following:

Parent/Guardian 1: % Relationship to Child/Adolescent:
Parent/Guardian 2: % Relationship to Child/Adolescent:

What is typically used for disciplining your child/adolescent (e.g., timeout, assigning chores, physical/corporal punishment, etc.)?

Are there any spiritual beliefs or values that you think may impact how you provide discipline or behavioral supports to your child? ☐ Yes ☐ No * If yes, please describe below.

Are there any cultural beliefs or values that you think may impact how you provide discipline or behavioral supports to your child? ☐ Yes ☐ No * If yes, please describe below.

GOALS

How would you best describe your child?

What are your child's strengths?

What are your goals for your child?

What do you want your child to learn in ABA therapy?

What behaviors would you like to be decreased/eliminated by ABA therapy?

What are your main concerns for your child currently?

What activities does your child enjoy the most?

What activities does your child enjoy the least?

What activity/toy/item is your child most motivated for?

SOH PEDIATRIC THERAPY CENTER

4908 S. Sheridan Road
Tulsa, OK 74145
Phone: (918)984-9153
Fax: (918)289-0579

CLIENT AGREEMENT – ABA-Applied Behavior Analysis Therapy

Soaring on Hope maintains a strong commitment to providing quality, results oriented therapy services to children. We ask that all families share in our commitment by playing an active role in the therapy process to ensure the best possible outcomes for your child.

Consent for Services

☐ I authorize Soaring on Hope to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by qualified, licensed, and trained health professional. I recognize, agree, and understand that I have the right to refuse treatment or terminate services at any time notifying Soaring on Hope in writing. In addition, Soaring on Hope may terminate services by notifying me in writing.

Authorization for Medical Treatment

☐ Office Practice/Clinic personnel at this clinic are hereby authorized to administer any medical, diagnostic, or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency, or extraordinary circumstances.

Observation/Assisting Release

☐ I understand that SOH participates with local colleges, universities and interested volunteers in allowing observation and assisting experiences within therapy sessions. These individuals are counseled prior to their observation and/or therapy assisting activities regarding confidentiality of patient information and agree to abide by SOH policies on confidentiality as part of their observation and assisting experiences.

Media Release

☐ I hereby **GIVE PERMISSION AND CONSENT** to all staff of Soaring on Hope to photograph, videotape and/or audiotape my child and/or myself during the time my child is enrolled in services. I/We give our permission and understand these photographs, videos and/or audiotapes will be used according to the therapist's discretion which could include, but not limited to, video modeling and other educational interventions, training for parents and/or staff, social media, website, and other promotional materials. Soaring on Hope will not disclose any of my child's personal information.

or

☐ I hereby D**O NOT GIVE PERMISSION AND CONSENT** to all staff of Soaring on Hope to photograph, videotape and/or audiotape my child and/or myself during the time my child is enrolled in services.

Hold Harmless

In consideration of Soaring on Hope LLC furnishing services and/or equipment to enable my child to participate in activities, I agree as follows:

☐ I, on behalf of myself, my personal representatives, and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Soaring on Hope LLC and its owners, agents, officers, and employees from any and all claims, actions or losses for bodily injury, property damage, loss of services or otherwise which may arise from my child's participation in activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE IT IS MY INTENTION TO INDEMNIFY AND HOLD HARMLESS SOARING ON HOPE LLC FROM LIABILITY FOR PERSONAL INJURY OR PROPERTY DAMAGE CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

HIPAA Privacy Notice Acknowledgement

☐ I understand that my child's and/or my medical records and billing information are made and retained by Soaring on Hope and are accessible to office personnel. Clinic personnel may use and disclose medical information for therapy treatment, counseling, functions and to any other physician or health care personnel involved in my child's and/or my continuum of care. Safeguards are in place to discourage improper access. Soaring on Hope and its staff are authorized to disclose all or part of my child's medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the Office/clinic's charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that SOH advise you that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease, related to mental health, drug, substance or alcohol abuse. By signing this agreement, you are consenting to such disclosure.

☐ A complete description of how your medical information will be used and disclosed by SOH is in our Notice of Privacy Practices (HIPAA). A copy is posted in this Office/Clinic. I was asked if I would like a copy of the Notice of Privacy Practices (HIPAA) form, and/or have received a copy of the Notice of Privacy Practices (HIPAA) form.

Release of Protected Health Information - Information will **ONLY** be released to the following individual(s): Please list yourself. Include type of access **ALL** or **LIMITED**. If limited, please be specific. Ex: Individual can drop off, pick up, make changes to schedule, and collaborate with therapist before and or after therapy, regarding child. Giving ALL access means all the above will be allowed.

Name	Relationship to Patient	Type of Access to patient	Phone #

Communication preference

ACCEPT DECLINE

☐ ☐ I grant permission to provide me with written communication via HIPAA complaint encrypted email service via my email provided on the patient demographics page.

☐ ☐ I grant permission to provide me with written communication via text message to my cell number which was provided on the patient demographic page. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ ☐ I grant permission for Soaring on Hope to leave relevant medical information on my voicemail.
I understand it is my responsibility to inform the clinic of changes to my preferred contact information or my communication preferences, as well as, to revoke the above authorization at any time.

I hereby certify that I have read and initialed each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original. This entire consent is valid from the date of my signature until closure of patient file or until I revoke it in writing which can be done at any time, without penalty.

Child's Name (Please Print) _____ Child's Date of Birth _____

Legal Guardian Name(please print) _____ Relationship to child _____

Legal Guardian Signature _____ Date Signed _____

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FINANCIAL POLICY

INSURANCE BENEFITS QUOTE POLICY

As an added service to you, Soaring on Hope will request insurance Benefit Quotes and Eligibility verification from your insurance provider. ***This is not a guarantee of coverage or payment.*** Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts such as deductible may change as additional claims are processed.

I understand that Soaring on Hope will assist with insurance precertification requirements but will not assume responsibility for precertification or any impact which it may have on insurance payment.

Please understand, if your insurance only allows a limited number of visits, it is your responsibility to keep track of visits as used.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I/my child am/is entitled, including Medicaid, private insurance, and third-party payers to ***Soaring on Hope.*** I hereby authorize said assignee to release all information necessary for processing. I authorize provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

It is policy to view fees for professional services as a charge to the client, not the insurance company. All co-pays and deductible amounts are due at time of service. As a courtesy to you, we will file your health insurance claim for the remainder of the charges with our in-network insurance companies. If you do not have insurance, it is expected that all fees be paid as services are rendered.

If claims are not paid or denied within 60 days, you are responsible for the account balance due. Payment of your portion is expected upon receipt to continue ongoing therapy sessions or services. You will be responsible for negotiating any disputed claims with your insurance company and to insure regular payment on your account. For your convenience, you may pay with cash, check, or credit card. If there is an overage on your account, it is suggested that the difference be credited to your account toward future treatment or refunded to you if therapy is complete.

Insurance will only pay for 1 evaluation per therapy service every 6 or 12 months. (181 /365 days) If your child has previously received an evaluation within 6/12 months, we will need a copy of that evaluation report. If you fail to mention that your child has already received an evaluation and insurance denies payment, you will be held responsible for the full payment amount.

_____

I have read and understand the Financial and Health Insurance Policy Statement of ***Soaring on Hope*** *and am agreeable to all the policies stated. I understand my responsibility for full payment on my account.*

I understand that if Insurance/Medicaid fails to pay for my child's evaluation since Insurance has already been billed for an evaluation in the past 6 or 12 months then I will be held responsible for the full amount of the cost of the evaluation. (Approx. $150)

I understand there will be a $30 NSF fee for all insufficient funds checks.

I understand if I have Private and/or Medicaid Medical Insurance and become ineligible, I will be responsible for any payments incurred during the ineligibility period.

Child's Name (please print)	Child's Date of Birth
Legal Guardian Name (please print)	Relationship to Child
Legal Guardian Signature	Date Signed

7/15/21-JA