Mailing: 219 Gerald Dr, Simpsonville SC 29681
Phone: (864) 757-9918
Fax: (864) 757-9921
Facebook: https://www.facebook.com/bhagogo.biz

Client Intake Packet

Please Select Your Location:

☐ Greenville ☐ West Columbia

Please Send ALL of the Following Mandatory Documents to: referral@bhagogo.biz

- This Intake Packet Completed in its Entirety
- Front and Back of Health Insurance Card for both Primary and Secondary Insurance
- Documents for ABA:
  - Formal ASD diagnosis from current DSM edition; based on psychological testing
- Documents for OT, PT, and SLP:
  - Last evaluation that occupational, physical, or speech therapist did
  - OT, PT, SLP Discharge Summaries

What We Offer

- ABA Therapy Services (20-40 hours/ week required)
- Case Management Services
- Live/online Support Groups
- Center based Occupational Therapy Services
- Center Based Physical Therapy Services
- Center Based Speech Language Pathology Services

Comprehensive ABA therapy

Treatment often involves an intensity level of 30-40 hours of 1:1 direct treatment to the client per week, not including caregiver training, supervision, and other needed services. However, very young children may start with a few hours (i.e. 4 hours) of therapy per day with the goal of increasing the intensity of therapy as their ability to tolerate and participate permits. Treatment hours are subsequently increased or decreased based on the client's response to treatment and current needs. Hours may be increased to more efficiently reach treatment goals. Decreases in hours of therapy per week typically occur when a client has met a majority of the treatment goals and is moving toward discharge.

Parent Availability

Behaviors A Go-Go provides ABA services following best practice. There are many critical factors involved for a child to develop and reach their fullest potential. Although the child is receiving the majority of services, it is *critical* that you, parent(s)/caregiver(s) are involved and participate throughout the entire service process. We require that you adhere to the appropriate amount of therapy and family/caregiver training, be a reliable team

member for maintaining services and engage in advanced planning by communicating with your assigned therapy team.

Client Information & Contacts

Referral Source Name (First & Last): ____

Relationship to Child: _______________________ Cell #: ___________________________________

Child's Name (First & Last): ____

DOB (MM/DD/YYYY): ___________________________________ Gender: M_____ F______

Child's Social Security #: ____

Parent(s)/Guardian(s) Name (First & Last): ____

Mom/Partner:	**Dad/Partner:**
Cell # ______________________	Cell # ______________________
Work # _____________________	Work # ______________________
Home # _____________________	Home # ______________________
Email ________________________	Email _________________________

Child's Current Address: ____

City: _____________________ State: _______________________ Zip: _________________________

County: ____

Drive Time/Mileage to 511 W Butler Road, Greenville 29607:
___hours _____minutes _____miles

Drive Time/Mileage to 3410 Sunset Boulevard, West Columbia 29169:
____ hours ____minutes_____miles

Primary Language Spoken in Home: ____

Emergency & Interpreter Information

Emergency Contact Name (First & Last): ____

Cell #: __________________ Home #:_____________________ Work #: ______________________

If an interpreter is currently working with the child, list their full name and phone number below:

Interpreter's Name: ______________________________ Phone #: __________________________

Insurance Information

Is child covered by Medicaid/Tefra? Yes ________ No __________

Primary Insurance: **Place an "X" in the box that indicates your primary insurance.**

- BlueCross Blue Shield Plan
- BlueChoice Health Plans
- Fee for Service Medicaid
- State Health Plan
- Cigna
- Tricare (Active Duty)
- Tricare (Retired Military)
- Other: ____

Cardholder Name (First & Last): ____
Cardholder SS #: _________________ Cardholder DOB (MM/DD/YYYY): ___________________
Relationship to Child:____
Name of Employer: __________________________ Work Phone: _______________________
Employer Address: ______________________ City: _____________ State:______ Zip:__________
Provider ID: __________________________ Policy #: ___________________________________
Group #: ___________________________ Member Services Phone #: _______________________
Do you have an annual deductible? Yes_____ No_____ If yes, amount ____________________
Do you have an annual copay? Yes ______ No _______ If yes, amount ___________________
Do you have any co-insurance or out of pocket amounts to be met during the calendar year?
Yes ________ No _________ If yes, amount _________________
Does the private insurance plan cover ABA, OT, PT, or SLP services*? Circle all that apply.
(* Documentation from insurance provider is required if services are not covered)

Secondary Insurance: (if applicable)

Secondary Insurance Name: ____
Cardholder Name (First & Last): ______________________ Relationship to child: _______________
Cardholder SS #: _________________ Cardholder DOB (MM/DD/YYYY): ___________________
Provider ID: __________________________ Policy #: ___________________________________
Group #: ___________________________ Member Services Phone #: _______________________
Does the private insurance plan cover ABA, OT, PT, or SLP services*? Circle all that apply.
(* Documentation from insurance provider is required if services are not covered)

AUTHORIZATION

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to Behaviors A Go-Go and companies working on their behalf, including vendors, other affiliates, and other service providers supporting Behaviors A Go-Go.

I authorize and consent for Behaviors A Go-Go to bill any and all insurance provided on my behalf.

Parent/Guardian Name: _________________________ Date (MM/DD/YYYY): __________________
Parent/Guardian Signature: _______________________________

Current Child's Healthcare Provider Team Information

Clinical Psychologist's Name & Practice: ____
Phone #: __________________________ Fax: _____________________________

Pediatrician's Name & Practice: ____
Phone #: __________________________ Fax: _____________________________

Developmental Pediatrician's Name & Practice: ____
Phone #: ____

Early Interventionist/ Case Manager's Name & Practice: __________________________________
Phone #: __________________________ Fax: _____________________________

Occupational Therapist's Name & Practice: ____
Phone #: __________________________ Fax: _____________________________

Physical Therapist's Name & Practice: ____
Phone #: __________________________ Fax: _____________________________

Speech-Language Pathologist's Name & Practice: _______________________________________
Phone #: __________________________ Fax: _____________________________

BELOW ARE THE MANDATORY DOCUMENTS/ASSESSMENTS THAT MUST BE SUBMITTED*

Required Documents	Name of Test	Date of Completion (*MUST be done 4-5 months PRIOR to receiving services)	Tester's Name and Credentials
-Formal Diagnosis of ASD -From current DSM edition* -Based on psychological testing*			
Medical Necessity Form			

EPSDT *(Most recent medical history and/or physical)

Services and Availability

Select Behaviors A Go-Go Services Desired (We operates all morning, all afternoon, or all day scheduling):

- ABA Therapy Services (20-40 hours/week required)
- Case Management Services
- Occupational Therapy Services
- Physical Therapy Services
- Speech Language Pathology Services
- Live/online Support Groups

Please indicate your child's availability and location for services from Monday - Friday 8:00 am - 6:30 pm

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
9:00 AM					
10:00 AM					
11:00 AM					
12:00 PM					
1:00 PM					
2:00 PM					
3:00 PM					
4:00 PM					
5:00 PM					
Address of Service:					
	Pets: Y / N	**Pets: Y / N**	**Pets: Y / N**	**Pets: Y / N**	**Pets: Y / N**
	Smokers: Y / N	**Smokers: Y / N**	**Smokers: Y / N**	**Smokers: Y / N**	**Smokers: Y / N**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION **(HIPAA)**

I,____________________________, hereby authorize Behaviors A Go-Go to release medical information including any information that may compromise or contain “Protected Health Information” (“PHI”) under Health Insurance Portability and Accountability Act (“HIPAA”).

I understand that this Authorization is executed for reason stated in the Policy and Procedures guidelines, and PHI will be released for purposes related to these matters.

I hereby acknowledge the receipt of the Notice of Privacy Practices, on the date set forth below. I understand that this Notice of Privacy Practices contains important information about my health information and that I should review the Notice of Privacy Practices.

I also understand that the PHI may be subject to state and federal law, but I expressly authorize the release of such information is specified herein. I understand that once this information is released, Behaviors A Go-Go can no longer control or be responsible for its use or re-disclosure. Once released, the information may no longer be protected under HIPAA.

I may revoke this Authorization at any time except to the extent that Behaviors A Go-Go has taken action in reliance upon it. In order to revoke this Authorization, I must submit a written request to Behaviors A Go-Go to the address set forth below. If not previously revoked, this Authorization will expire on date of discharge.

If I have any questions or complaints, I understand that I may contact Behaviors A Go-Go at (864)757-9918, or at the address listed below, first. In addition, if I have a complaint, I may inform the United States Office of Civil Rights, Medical Privacy Complaint Division, U.S. Dept. of Health and Human Services at:

200 Independence Ave., South West, HHH Building, Room 509H, Washington, DC, 20201
Phone: (866) 627-7748

Dated: _________________

Patient Name: _______________________________

Signed: _______________________________________

(Patient, Parent, or Guardian)

219 Gerald Drive, Simpsonville, SC 29681   Phone: (864)757-9918   Fax(864)757-9921   Email: help@bhagogo.biz

APPOINTMENT PUNCTUALITY & CANCELLATION POLICY FOR ALL SERVICES

We here at Behaviors A Go-Go strive to provide excellent service for you. Part of this process depends upon you and your child attending all scheduled sessions. Our office requires a 24-hour notice for appointments that need to be cancelled or rescheduled. Please be punctual for your scheduled appointments. If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for your benefit, as well as for the other patients being seen. We appreciate your business and to better serve you, we need all appointments appropriately managed. For this reason, 3 cancellations without a 24-hour notice or 3 no shows without proper notification will result in you being **discharged** from our therapy program.

In the event that a service provider cancels a session with a client who receives multiple disciplines per day, the parent/caregiver is responsible for their child attending all other scheduled sessions for that day. A failure to do so will result in an **unexcused cancellation** by client.

Please notify us by the following methods:

Weekdays & Weekends

Email: schedule@bhagogo.biz

Schedule Phone: (864) 757-9918

Please leave us a message by your preferred method **at least** 24 hours in advance. We appreciate your cooperation in this matter and thank you for your business.

I have read and understand this policy.

______________________________________ ____________________

Parent/Guardian Signature Date

AUTHORIZATION AND CONSENT FOR **TREATMENT AND MEDICAL EMERGENCY** RELEASE FORM

I,____, consent for the staff of Behaviors A Go-Go, LLC to access and obtain medical services appropriate for the emergency medical care of my child, ________________________ in my absence.

I hereby authorize for the emergency transport of my child to the nearest emergency medical facility should this be deemed necessary.

I also authorize in my absence, the emergency department authority to provide immediate and appropriate medical services and treatment of my child's injury or illness.

My signature below authorizes parental consent of medical information compliant with HIPAA regulation for my child, ____.

Medical Information and Conditions: ____
____

Is the client on any medication? If so, what medication? _____________________________
____

Allergies: ____
____

Signature: __________________________ Relationship:____________________________

Date: ____________________ Emergency Contact Number:_________________________

CONSENT FOR RELEASE FOR APPOINTMENT **REMINDERS**

I, ______________________________, hereby authorize Behaviors A Go-Go to send me an appointment reminder via (circle one) – Email or phone – using the following information.

Please Note: Email reminders may contain client or center information such as, but not limited to, client first name and center location.

Parent/Guardian Contact Information:

(Please print clearly and legibly)

Email: ____

Phone Number: ____

Child/Client's Name:____

Signature: ____

Date: ________________________________

AUTHORIZATION FOR RELEASE/OBTAIN INFORMATION

Client's Name: ________________________ Client's DOB: ______________________________

Name of Parent/Guardian: ____

I authorize Behaviors A Go-Go to:

- Obtain information from
- Release Information to

Name: ______________________________ Agency:___________________________________

Address: ____

Telephone: __________________________ Fax: ___________________________________

Email:____

Parent Signature: ______________________________ Date: _____________________

Records to be released/obtained including the most recent:

____

____

AUTHORIZATION FOR RELEASE/OBTAIN INFORMATION FOR **MEDICAID TARGETED CASE MANAGEMENT**

Client's Name: ___________________________ Client's DOB: _________________________________

Name of Parent/Guardian: ____

I authorize Aging with Flair to:

- Obtain information from
- Release Information to

Name: _________________________________ Agency:______________________________________

Address: ____

Telephone: _____________________________ Fax: _______________________________________

Email:____

Parent Signature: _________________________________ Date: _______________________

Records to be released/obtained including the most recent:

____

____

Behaviors A Go-Go, LLC has contracted with Aging With Flair, LLC to provide Medicaid Targeted Case Management to

those who choose to use service.

Parent / Caregiver Questionnaire

Confidential

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial assessment. Please feel free to add any additional information that you think may be helpful in understanding your child. Behaviors A Go-Go, LLC will hold information provided by you strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information.

Name of Person Filling Out Document: ___________________________________

Relationship to Child: ______________________

Nickname or name child routinely goes by: _____________________________________

School Name: ___________________________

School District: __________________________________ Grade: ________________________

Who referred you to our office? ____

Please describe the problems your child is now having, and your top three things you would like your child to benefit from ABA services. Please use the back of this page for additional space.

____

____

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____

INDICATE PARENTS/GUARDIANS LIVING IN THE HOME:

Marital Status (Circle): Married   Remarried   Divorced   Separated   Widowed   Single   Cohabitants

If divorced, who has physical custody? ___________________ Is it full or joint? _____________

Who has legal custody? ___________________ Is it full or joint? ______________________

Mother's Name: ____

Date of Birth: ____________________________ Age:_______________

Occupation: ___________________________________

Employer: ______________________________________

Education Completed: ________________ Health (Circle): Excellent Good Fair Poor

Father's Name: ____

Date of Birth: ____________________________ Age:_______________

Occupation: ___________________________________

Employer: ______________________________________

Education Completed: ________________ Health (Circle): Excellent Good Fair Poor

Does either parent's job require him/her to be away from home long hours or extended periods? ______

If married, how long have you been married? __________________________________

If divorced, how long have the biological parents been divorced? _____________________

Has either parent been married before or since? Mother: __________ Father: ____________

Please list the name(s) of the stepparents: ___________________________________

If yes, provide dates of previous marriage(s), names, and ages of children from these marriages:

Mother: ______________ Children & Ages: __________________________________

Father: ________________ Children & Ages: ________________________________

Is there a birth parent living outside of the home? If so, circle: Mother Father

Name: ____________________ Where do they live? _______________________

If birth parent(s) do not live in the child's home, how much contact does the child have with the parent not having custody, with step siblings, etc.?

____

____

____

____

____

Siblings:

	Name	Age	Relationship	Living in Home?	School	Grade
1.	_____________	_____	_________________	____Y/N____	______________	_________
2.	_____________	_____	_________________	____Y/N____	______________	_________
3.	_____________	_____	_________________	____Y/N ____	______________	_________
4.	_____________	_____	_________________	____Y/N____	______________	_________

*Please list additional siblings in the above format on the back of this page.

Please indicate any special needs of concerns regarding the other children living in your home:

____

Are there any other people who have a significant role in how this child is raised?

____

____

____

____

____

PSYCHOLOGICAL HISTORY:

Is there a history in your immediate family or in the mother's or father's extended family of Autism Spectrum Disorders? If so, who?

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

DEVELOPMENTAL HISTORY:

1. **Please indicate the age at which your child did the following:**
   Rolled over consistently _______
   Sat up unsupported _______
   Stood _______
   Crawled _______
   Walked unassisted _______
   Said 1st word intelligible to strangers _______
   Said 2-3 word phrases _______
   Used sentences regularly _______
   Toilet trained during the day _______
   Dry through the night (6+ nights) _______
   Dressed self _____

2. **Please indicate if your child is experiencing any of the following:**

Isolated socially from peers		Stress from conflict between parents	
Problems making friends		Legal situation (anyone in the family)	
Problems keeping friends		History of abuse	
Problems getting to sleep		Alcohol/drug use/ abuse	
Problems controlling temper		School concentration difficulties	
Problems sleeping through the night		Grades dropping or consistently low	
Trouble waking up		Sadness or depression	
Fatigue/tiredness during the day		Anxiety	
Nightmares		Problems with authority	
Bed Wetting		Soiling	

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

____

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____

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____

____

4. List any medications your child is currently taking or has taken for extended periods (give dates and dosage level, if possible):

____

____

____

____

5. Child's current height: ________ Ft. _______ In. Weight: __________ Lbs.

6. With which hand does the child write?______________________

7. Does the child have any hearing problems? ____

8. Does the child have any additional diagnosis excluding ASD? (for example: allergies and diet restrictions):

____

____

EDUCATIONAL HISTORY:

1. List in chronological order all schools your child has attended:

Name	System	Years	Grade	Special Ed.?

2. Name(s) of current teacher(s): ____

3. Does your child's teacher have concerns about him/her? (list):

____
____
____
____

____

4. Has your child ever repeated a grade? Y/N _____ If yes, what grade(s)? ______________

5. If your child has been in Special Education, did they have a:

______ 504 Plan ________ Psychological Eval. _______IEP

______ Speech Eval. _______ Behavior Intervention Plan _______ Physical Therapy Eval.

______ Occupational Therapy Eval. ________ Adaptive Technology Eval.

______ Other(s): _______________________________________

6. If your child has been in Special Education, how were they served?

- Consultation
- Collaborative Education
- Pull-Out
- Special Program
- Resource Classroom
- Team Taught Classes
- Self-Contained Classroom
- Psychoeducational Center

7. Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

8. List any special abilities, skills, and strengths your child has:

GENERAL INFORMATION

1. Please list the 3 things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying “I want my child to be more responsible”, translate that into actual behaviors such as doing household chores, caring for brothers and sisters, etc.

Like Child to Do More Often	Like Child to Do Less Often
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________

2. List any short-term goals for your child, as in being able to accomplish in 6 months to 1 year.

3. List any long-term goals for your child, as in being able to accomplish in 5-10 years.

4. What do you already know about Applied Behavior Analysis?

Thank you very much!