Mailing: 219 Gerald Dr, Simpsonville SC 29681
Phone: (864) 757-9918
Fax: (864) 757-9921
Website: behaviorsagogo.com

Client Intake Packet

Please Select Your Location:

☐ Greenville ☐ West Columbia

Please send ALL of the following documents to: referral@bhagogo.biz

- This completed intake packet.
- Copies of the front and back of health insurance card(s) 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 ST:
  - Last evaluation for Occupational, Physical, or Speech therapies.
  - OT, PT, ST Discharge Summaries.

What We Offer

- ABA Therapy Services
- Center-based Speech Therapy Services
- Center-based Occupational Therapy Services
- Center-based Physical Therapy 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.

Referral

Referral Source Name (First & Last): _____

Relationship to Child: _____ Cell #: _____

Client Information & Contacts

Child's Name (First & Last): _____

DOB (MM/DD/YYYY): _____ Gender: ☐ Male ☐ Female

Child's Social Security #: _____

Mom/Caregiver	***Dad/Caregiver***
Name: _____	Name: _____
Phone: _____	Phone:_____
Email: _____	Email: _____

Child's Current Address: _____

City: _____ State: _____ Zip: _____

County: _____

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 #: _____

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Insurance Information

Is child covered by Medicaid/Tefra? ☐ Yes ☐ No

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

☐ Absolute Total Care MCO ☐ Aetna Healthcare

☐ BlueCross Blue Shield Plan ☐ BlueChoice Commercial Health Plans

☐ Cigna ☐ Fee for Service Medicaid

☐ Healthy Blue MCO ☐ Humana Healthy Horizons MCO

☐ Molina Healthcare MCO ☐ Select Health MCO

☐ State Health Plan

☐ 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 (Check all that apply):

☐ ABA, ☐ OT, ☐ PT, or ☐ ST services*

* Documentation from insurance provider is required if services are not covered.

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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 (Check all that apply):

☐ ABA, ☐ OT, ☐ PT, or ☐ ST services*

* Documentation from insurance provider is required if services are not covered.

Authorization for Release of Medical Information

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: _____

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Current 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 Name & Practice: _____
Phone #: _____ Fax: _____

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)			

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Services and Availability

Select Behaviors A Go-Go Services Desired (check all that apply):

☐ ABA Therapy Services (20-40 hours/week required)

☐ Occupational Therapy Services

☐ Physical Therapy Services

☐ Speech Therapy Services

Please indicate your child's availability:

	Monday	Tuesday	Wednesday	Thursday	Friday
9:00 – 10:00 AM					
10:00 – 11:00 AM					
11:00 – 12 Noon					
12 Noon – 1:00 PM					
1:00 – 2:00 PM					
2:00 – 3:00 PM					
3:00 – 4:00 PM					
4:00 – 5:00 PM					

Location of Services Requested ☐ Center ☐ Home

If home services, are there pets in the home? ☐ Yes ☐ No

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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 Telephone: (866) 627-7748

Date: _____

Patient Name: _____

Signed: _____

(Patient, Parent, or Guardian)

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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:_____

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Consent For Release For Appointment Reminders

I, _____, hereby authorize Behaviors A Go-Go to send me an appointment reminder via ☐ Email ☐ Text ☐ Telephone – using the following information.

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

Parent/Guardian Contact Information:

Email: _____

Phone Number: _____

Child/Client's Name:_____

Signature: _____

Date: _____

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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:

_____

_____

_____

_____

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Confidential Parent / Caregiver Questionnaire

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 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.

Name of Person Filling Out Document: _____

Relationship to Child: _____

Nickname or name child routinely goes by: _____

INDICATE PARENTS/GUARDIANS LIVING IN THE HOME:

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Cohabitants

If divorced, who has physical custody? _____ ☐ full ☐ joint

Who has legal custody? _____ ☐ full ☐ joint

Mother/Caregiver's Name: _____

Date of Birth: _____ Age:_____

Occupation: _____

Employer: _____

Education Completed: _____ Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Father/Caregiver's Name: _____

Date of Birth: _____ Age:_____

Occupation: _____

Employer: _____

Education Completed: _____ Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

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If married, how long have you been married? _____

Has either parent been married before or since? ☐ Mother ☐ Father

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

Is there a birth parent living outside of the home? ☐ Mother ☐ Father

Name: _____ Where do they live? _____

Siblings

Name	Age	Relationship	Living in Home?	School	Grade
1. _____	_____	_____	☐	_____	_____
2. _____	_____	_____	☐	_____	_____
3. _____	_____	_____	☐	_____	_____
4. _____	_____	_____	☐	_____	_____

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

_____

_____

_____

_____

List any medications your child is currently taking or has taken for extended periods (give dates and dosages).

_____

_____

_____

_____

Child's current height: _____ Ft. _____ In. Weight: _____ lbs.

With which hand does the child write? ☐ Right ☐ Left

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Does the child have any hearing problems? ☐ Yes ☐ No

If yes, Specify: _____

Does the child have any additional diagnoses excluding ASD?

_____

_____

_____

_____

EDUCATIONAL HISTORY

List in chronological order all schools your child has attended:

Name System Years Grade Special Ed.?

_____

_____

_____

_____

Name(s) of current teacher(s): _____

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

_____

_____

_____

_____

Has your child ever repeated a grade? ☐ Yes ☐ No If yes, Specify: _____

If your child has been in Special Education, did they have (Please check):

☐ 504 Plan ☐ Psychological Eval. ☐ IEP

☐ Speech Eval. ☐ Behavior Intervention Plan ☐ Physical Therapy Eval.

☐ Occupational Therapy Eval. ☐ Adaptive Technology Eval.

☐ Other(s): _____

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Intake Information

Top concerns/ what brought you to ABA services:

_____

_____

_____

_____

_____

Like Child to Do More Often

_____

_____

_____

Like Child to Do Less Often

_____

_____

_____

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

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

Thank you very much!

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