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Welcome to the BC Family!

Dear Parent/Guardian,

Thank you for your interest in Behavioral Connections! We are committed to providing intensive intervention services to children diagnosed with Autism, Pervasive Developmental Disorder (PDD), Asperger's Syndrome, or related disability. We use a combination of Applied Behavior Analysis (ABA) and a subspecialty of ABA called Applied Verbal Behavior (AVB). ABA and AVB are scientifically validated treatments and can be delivered in the home, community, and/or our 3 clinics. We also offer family/parent training and support to help you manage everyday life with your child. Parents or family members will be expected to consult with the BCBA for a minimum of 1 hour per week. This time can be broken up over the week into 4-15 minutes, 2-30 minutes or 1-hour meetings via zoom, phone or in person. Also note your child will be assigned RBT's who will execute the intervention and a BCBA who will oversee and guide the intervention. Please note that we work as a TEAM and you might see or hear from different RBT's and BCBA's.

Enclosed is an intake packet which will help us get to know your child, so it's important to fill it out as completely as possible. We'll use the information you provide to help us establish positive relationships with your child, which then lead to successful intervention and treatment. After we receive your packet, we have to get approval for treatment, which can take 2 – 4 weeks or longer, depending on your health insurance. Once we receive approval, we will contact you to schedule an evaluation of your child's needs, develop a treatment plan, and set up therapy sessions to match your availability.

To help provide further security and safety to the patients, families and staff each location has surveillance cameras at all entrances and throughout the buildings.

We believe families are an important part of any treatment and we want both you and your child to experience success. Starting intensive ABA services can seem overwhelming, so we encourage you to call us at any time in order to ask questions or relay concerns Bridgewater: (508) 807.4996, New Bedford (508) 994.3000 or Norwood (781) 352.8047. Again, we thank you for choosing Behavioral Connections and look forward to working with you and your child.

Sincerely,

Team BC

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Intake Packet

Thank you for selecting us at Behavioral Connections to help meet the needs of your child. We understand that some of these forms may be challenging and time consuming. The more information we have, the better able we will be to assist you and your family. If at any time in this process you have any questions, please contact us.

The intake packet includes the following:

- Application for Behavior Services
- Service Options
- Medical Information
- Behavior
- School / Job Attended by Applicant
- Reinforcement Assessment Form
- Fee For Service Agreement
- Contract For Service
- Authorization for Release of Information
- Confidentiality Statement for Therapy Observation
- HIPAA Privacy Notice

Please note the following documents are required before we can move forward with the intake process. If we have a waitlist we are unable to place you on the list until your file is complete.

- ☐ Fully Completed Intake Packet
- ☐ Diagnostic Evaluation
- ☐ A dated prescription for ABA from your child's primary physician or developmental specialist.
- ☐ IEP or IFSP (if applicable)
- ☐ Photocopy of Primary and Secondary Insurance Cards
- ☐ Copy of your child's most recent physical examination notes

*****All forms must be signed and returned to Behavioral Connections before the onset of services.*****

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APPLICATION FOR BEHAVIOR SERVICES

Who referred you to us?	

For clinic services which location?	New Bedford	☐	Bridgewater	☐	Norwood	☐

PATIENTS INFO:

Patients Full Name?						
Date of Birth?						
Address? Street, city, state, zip						
Primary Diagnosis?						
Secondary Diagnosis?						
Age diagnosis given?						
Date diagnosis given?						
Diagnosing Physician?						
How was the patient diagnosed?	Observation?	☐	Parent Report?	☐	Direct Testing?	☐

Guardian/'s INFO:

Legal Guardian full names?			
Relationship to Patient?			
Social Security Numbers?			
Address? Street, city, state, zip			
Phone numbers?	Home:	Work:	Cell:
Phone numbers?	Home:	Work:	Cell:
Email?			
Occupation?			
Employer?			
Title?			
Legal restrictions with parents?			
Who lives with the Patient? Names of adults			
Who lives with the Patient? Name and age of other children			

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Service Options

Services interested in: Please select the type(s) of therapy services you would like to receive *(please note that while we will attempt to provide the type of service you request, not all services may be available at time of request):*

☐	Clinic Based Services
☐	Social Skills Groups / Play Therapy
☐	Home Based Services
☐	Community Based Services
☐	School Based Services
☐	Toilet Training Program
☐	Parent Training / Staff Training
☐	VB-MAPP assessment & Program Recommendations
☐	Telehealth Services

Thank you for your request, your request will be added to our current wait list. We will be contacting you to discuss the availability of services. A minimum of 10 hours per week for direct service is required unless not deemed medically necessary.

The undersigned hereby acknowledge that the information contained in this application is accurate in all respects.

PARENT/GUARDIAN: _____ Date: _____

PARENT/GUARDIAN: _____ Date: _____

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
8:30 am – 11:00 am OR	☐	☐	☐	☐	☐
9:00 am – 11:00 am	☐	☐	☐	☐	☐
11:00 am – 1:00 pm	☐	☐	☐	☐	☐
1:00 pm – 3:30 pm	☐	☐	☐	☐	☐
3:30 pm – 5:30 pm	☐	☐	☐	☐	☐

*Please note that the potential schedule will be based on medical necessity and staff availability.

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MEDICAL BACKGROUND

Primary Care Physician & Practice name:	
Address: city, state, zip	
Physician's Phone:	
Physician's Fax:	
Date of last well check?	
Medical Conditions?	
Past Surgeries?	
Allergies?	

Specialist:

Specialist name & practice name?	
Address: city, state, zip	
Physician's Phone:	
Physician's Fax:	
Date of last well check?	

Medications:

Medication Name	Start Date	Dosage	Medication Used to Treat	Prescribing Doctor?

*Please notify your child's supervisor any time there is a change in medication or dosage of medication.

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Behaviors

Physical Stereotypy	**YES**	**NO**
Does your child flap his hands/arms?	○	○
Does your child seem to look at his fingers in a stereotypic way?	○	○
Does your child seem to look out of the side of his/her eyes?	○	○
Does your child walk on his/her toes?	○	○
Does your child rock (sit and rock back and forth)?	○	○
Verbal Stereotypy:	**YES**	**NO**
Echolalia – repeats what is said/heard – Immediately?	○	○
Echolalia – delayed – (will repeat what's been said/heard later)?	○	○
Inappropriately humming to self?	○	○
Scream or yell inappropriately?	○	○
Perseveration:	**YES**	**NO**
Does he/she get stuck on a topic?	○	○
Get obsessive about specific people?	○	○
Get obsessive about specific objects?	○	○
Transition/Routines:	**YES**	**NO**
Has trouble with sudden change?	○	○
Has trouble with changes that they are warned about?	○	○
Does your child fear any specific objects, animals, places or people? If yes, explain:	○	○
Tantrums/Aggression/Self-Injury:		
Does your child have tantrums that you feel need to be addressed? Describe behavior:	○	○

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Does your child have any of the following conditions? & explain.

	YES	NO			
Seizures?	○	○	Describe:		
Date of last Seizure?			Does your child use Diastat or other medications during seizures?	YES ○	NO ○
Please sign here to administer medication:				**Date:**	
Special Diet?	○	○			
Describe:					
Hearing Problems?	○	○			
Describe:					
Visual Impairment?	○	○			
Describe:					
Does your child have an Epipen?	○	○			
Describe:					

*Emergency Contacts: * please note we contact parents first*

Name?		Relation?	
Phone Number		Address? Street, city, Zip	
Name?		Relation?	
Phone Number		Address? Street, city, Zip	

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Patient's History:

	Yes	No	
Did the Patient receive Early Intervention Service?	◯	◯	Agency Name:

School?			
Address? Street, City, State, Zip			
Teacher/Contact Name?		Grade?	
Phone Number?		Email?	

Occupational Therapy:

Agency name?		Therapist Name?	
Address? Street, City, State, Zip			
Phone?		Email?	

Speech Therapy:

Agency name?		Therapist Name?	
Address? Street, City, State, Zip			
Phone?		Email?	

Psychologist/LCSW:

Agency name?		Therapist Name?	
Address? Street, City, State, Zip			
Phone?		Email?	

By signing below, you give Behavioral Connections the consent for the release of any information regarding the patient and all medical and non-medical records.

Parent/guardian:_____ Date _____

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Reinforcement Assessment Form

Prior to beginning services, it is important to identify ALL of your child's motivators or potential reinforcers. Many children have very specific reinforcers and some like to use them only in particular ways. Please provide as much detail as possible about your child's reinforcers. Please list out the items and use a scale of 1-5 (1 being the most favorable) for each category.

What are your child's preferences?

Movies:	**Television shows/cartoons:**	**Songs:**
List other videos or movies your child likes:		

What is your child's favorite snacks?

Candy:	**Fruit:**
Cookies:	**Crackers:**
Chips:	**Pretzels:**
Other Snacks:	**Favorite Drinks:**
Favorite Books:	**Favorite Toys:**

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Skill Level:

*Providing us with information below, this will help our team prior to assessment to better understanding your child.

List all the items the patient request/asks for? (E.g., cookie, chip, I want a movie, etc.) **Please indicate vocal, signs, or pictures?**	
List the directions that the patient follows consistently? (E.g., "go get your coat!" Patient goes and gets his/her coat, "Clean up the Lego's!" Patient begins cleaning up the Lego's.)	
List the ongoing words the learner understands? (E.g., car, mom, dad, Elmo, wheel, nose, arm, finger nail, etc.)	

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Health Insurance

Primary Insurance?		Member #	
Secondary Insurance?		Member #	
Primary coverage start date?		Secondary coverage start date?	
Subscribers Name?		Subscribers Date of Birth?	
Subscribers Address?		Relationship to patient?	

***Please provide a copy of front and back of the member card/s.**

Fee For Services

Insurance coverage for clients. Co-Pays/Deductibles will be billed directly to client or secondary insurance. I (_____) agree to pay co-pays based on my agreement with my insurance carrier. Copays/deductibles are an agreement between insurance and (you) the member not the provider. If you do have a copay/deductible for aba services we will inform you prior to commencement of services and what that cost will be.
Contact BC immediately if your insurance changes. If your insurance changes it is up to you to inform us via email, or mail prior to the change. At which time we would also ask for a copy of the new insurance card. If any charges accrue and the insurance doesn't accept the charges you will be billed for said services that were not covered.

*By signing below, you agree to pay for any co-pays/deductibles or services not covered by your insurance.

Parents signature

Print Name		Social Security Number	
Parent Signature & Date:			

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Informed Consent

Patients Name		Date of Birth	

STATEMENT OF AUTHORITY TO CONSENT:
I certify that I have the authority to legally consent to assessment, release of information, and all legal issues involving the above- named client. Upon request, I will provide Behavioral Connections with proper legal documentation to support this claim. I further hereby agree that if my status as legal guardian should change, I will immediately inform Behavioral Connections of this change in status and will further immediately inform Behavioral Connections of the name, address, and phone number of the person or persons who have assumed guardianship of the above-named client.

TREATMENT CONSENT: I consent for behavioral treatment to be provided for the above- named client by Behavioral Connections and its staff. I understand that the procedures used will consist of manipulating antecedents and consequences to produce improvements in behavior. At the beginning of treatment behavior may get worse in the environment treatment is provided (e.g., "extinction burst") or in other settings (e.g., "behavioral contrast"). As part of the behavioral treatment, physical prompting and manual guidance may be used. The actual treatment protocols that will be used have been explained to me.

I understand that I may revoke this consent at any time. However, I cannot revoke consent for action that has already been taken. A copy of this consent shall be as valid as the original.

Parent/Guardian signature:		Date:	
Witness signature:		Date:	

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Photo/Video & Data Release Form

I hereby grant Behavioral Connections, permission to use my likeness in a photograph/video & data collected, without payment or any other compensation. If the participant is under 21, there must be consent by a parent or guardian, as follows: I hereby certify that I am the parent/guardian of_____,(Child's Name) and do hereby give my consent without reservation to the foregoing on behalf of said person. I am 21 years of age and am competent to contract on my own behalf. I have read this release form before signing below, and I fully understand the contents, meaning, and impact of this release. **Behavioral Connections use video/photo and data for staff trainings purposes only.** Any other use of video/photo, data the parent or legal guardian will be notified prior to use.

I SIGN THIS RELEASE FREELY AND VOLUNTARILY

Print Name of Minor:		Print Name of Parent/Guardian:	

Signature of Parent/Guardian	

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Authorization for Release of Information

Patients Name:		Date of Birth:	
Patients Address: Street, City, State, Zip			

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying Behavioral Connections in writing. However, the revocation will not have an effect on any actions Behavioral Connections took before it received the revocation.

I authorize Behavioral Connections and its affiliates to receive from or disclose my individually identifiable health information to the following person(s) or organization(s): (Please Identify a **Psychiatrist, Neurologist, Licensed Psychologist, LMHC, Developmental/Behavioral pediatrician, or Primary Care Physician** that oversees your child's medical wellbeing.)

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Authorization for Release of Information

Primary Physician & Name of Practice:			
Address: Street, City, State, Zip			
Phone:		Fax:	
Name of Specialist & Practice Name:			
Address: Street, City, State, Zip			
Phone:		Fax:	

Description of individually identifiable health information to be received or disclosed (check appropriate type(s) of information):
All relevant information related to my healthcare services

- Claims
- Eligibility/Benefits
- Information used to make benefit determinations
- Treatment Plan(s)
- Progress Reports: Changes in medication, mental state, and/or medical diagnoses

The purpose of this authorization is (check all that apply):

- To allow the appropriate management of treatment, and/or services
- Other (describe):

All dates of records will be disclosed unless you indicate differently below.
From_____(MM/DD/YYYY) To_____(MM/DD/YYYY)
THE MEMBER OR MEMBER'S REPRESENTATIVE MUST COMPLETE THE REST OF THIS FORM:
I understand that this authorization will expire: On_____(MM/DD/YYYY) or one year from the date of the signature below (or as set forth in the applicable state-specific provisions below).

Print personal representative's name:		Date:	
Signature of representative:			
Address: Street, City, State, Zip			
Phone:		Relationship:	

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HIPAA Privacy Notice

HIPAA Privacy Notice

Behavioral Connections complies with the guidelines and policies regarding the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT or HIPAA. This law protects client/patient information. Under this law, you have the following rights:

- The client (parents of child) has the right to read and copy any information written about the client including: data collection, clinical reports, assessments, etc.
- The client has the right to request a change to their information.
- The client has the right to request restrictions on certain uses and disclosures of information. The client has the right to receive an accounting on the disclosures (releases) of information.
- The client has the right to adequate notice about the use and disclosure of their information, individual rights to see/get copies/request amendments to records, provider/therapist duties, and how to make a compliant and get information.
- The client has the right to obtain a written copy of the Notice of Privacy Practices.

Please sign and date below that you have read and understand this policy.

Name of Patient:	
Name of Parent/Guardian:	
Signature of Parent/Guardian:	
Date:	

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