Phone (813) 374-2070
Fax (813) 337-0937

550 N Reo St., Suite 202
Tampa, Florida 33609

Intake Form (Updated March 2017)

CHILD INFORMATION	Today's Date:
Last Name:	Age: yrs months
First Name:	Date of Birth:
Home Phone:	SSN:
Address:	City:
County:	State:
Referred By:	Zip:

Primary Diagnosis:	Date of Diagnosis:
Secondary Diagnosis:	Date of Diagnosis:
Other Conditions:	Date of Diagnosis:

LEGAL GUARDIAN INFORMATION	
Full Name:	Relationship to Child:
Address: (If different from applicant)	
City:	State:
Occupation:	Name of Employer:
Home Phone: (If different)	Business Phone:
Cell Phone:	Email:
Full Name:	Relationship to Child:
Address: (If different from applicant)	
City:	State:
Occupation:	Name of Employer:
Home Phone: (If different)	Business Phone:
Cell Phone:	Email:
With Whom does the Child Reside:	
Does the Child have regular visitation with a non-custodial parent?	
Is there anyone else involved regularly with your child's care?	
Name:	Name:
Relationship:	Relationship:

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MEDICAL INFORMATION			
Is your child on medication?	Yes	No	
Primary Care Physician:	PCP Phone Number:		
DAN Doctor:			
Special Diets:			
List Medication, Administration times, and usage:			
Type of Medication	Dosage	Administration Times	Used For

SCHOOL AND OTHER INTERVENTIONS
Name of School:
Grade:
List any difficulties your child has in school (academic and/or behavioral):
Has your child ever repeated a grade: Yes No If yes, what grade:
Has your child ever been assessed through the school system? Yes No *If yes, please provide the results to the Behavior Analyst
Does your child currently receive any services in the school system? Yes No Explain:

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Please list the days and times that you would like services to be provided. We will make all attempts to fulfill the times you request but cannot guarantee availability.
Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:

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INSURANCE VERIFICATION FORM				
Today's Date:			Diagnosis:	
PATIENT INFORMATION				
Patient's Last Name:	First:		Middle:	
Birth date:	Age:		Sex:	
Social Security Number:		Nickname:		
Street Address:		Apt #:	City:	
State:	Zip:	Home Phone:		
Parent (s) last name:		Parent (s) first name:		
Marital Status:	Occupation:			
Employer:		Employer Phone:		
Primary Care Physician (PCP):				
INSURANCE INFORMATION				
Person Responsible for bill:			Birth Date:	
Address (if different):			Phone #:	
Occupations:	Employer:			
Employer Phone #:	Employer Address:			
Is this patient covered by insurance? Yes				
Primary Insurance:				
Claims Address:				
Insurance Phone #:	Coverage Effective Date:			
Subscriber's Name:		Subscriber's SSN:		
Birth Date:	Patient's relationship to subscriber:			
Group #:	Policy #:		Co-Payment $:	
Secondary Insurance (if applicable):				
Subscriber's Name:		Subscriber's SSN:		
Birth Date:	Patient's relationship to subscriber:			
Group #:	Policy #:		Co-Payment $:	

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IN CASE OF EMERGENCY
Name of local friend or relative (not living at the same address:
Relationship to patient:
Home Phone:
Work Phone:
Cell Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Advanced Behavioral Systems, Inc. or insurance company to release any information required to process my claims.

We will submit your claims; however, we must emphasize that as health care provers, our relationship is with you, not your insurance company. Although we attempt to verify your ABA/Autism benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of inquiry.

By signing below you confirm that you understand:

It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.

- If your insurance policy requires a prescription from your primary care physician, it is your responsibility to have that faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service (s) is being provided to you and if it is not a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you contact us promptly for assistance in the management of your account. If you have any questions of concerns about the information, please do not hesitate to ask us. We are here to help you.

Parent/Guardian Signature Date

Please print name here

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SERVICES NEEDS:

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):

- **Applied Behavior Analysis Services**
- Home Based YES
- Clinic Based YES
- Behavioral Babysitting YES
- Community Based Services YES
- School Based Services YES
- Intensive Feeding YES
- Toilet Training Program YES
- Parent/Caregiver Training YES
- Staff Training YES
- Social Skills YES

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

Parent/Guardian (print name) :

Signature of Parent/Guradian:

Date:

If there is additional information to provide, please attach a separate sheet.

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INTAKE CHECKLIST:

After completing the electronic intake packet, please be sure to bring the following documents/items to your appointment with our Client Care Team!

- **Copy of Prescription from M.D. that States:**
  - **Name of Patient**
  - **Date of Birth**
  - **Diagnosis**
  - **Requesting ABA-Behavioral Services**
- Copy of most recent IEP
- Copy of most recent comprehensive evaluation
- Copy of most recent speech/occupational therapist evaluations and goals
- The Functional Analysis Questionnaire (if applicable)
- Video footage of problematic behavior instances (if applicable)