Dear prospective client,

Thank you for your interest in Progressive ABA Therapy Group, LLC. Here you will find all necessary consent forms and documentation that must be completed prior to receiving services from our therapy team. Please complete the forms in their entirety. A checklist is provided below to ensure all documentation is complete. We also ask that you provide our team with pertinent medical and educational records such as copies of diagnostic evaluations, Individualized Education Plans (IEP's) and educational evaluations (ETR) so that we can provide your child with the highest quality of care. We look forward to working with you and your child.

Sincerely,

Progressive ABA Therapy Group

**Intake Checklist**

_____ Consent to Treatment
_____ Picture and Video Release
_____ Client Financial Responsibility and Consent to Bill Insurance
_____ Notice of Privacy Practices
_____ Intake Questionnaire
_____ Authorization to Release Information
_____ Review of Policies and Procedures
_____ Diagnostic Evaluation
_____ Individualized Education Plan (IEP)
_____ Evaluation Team Report (ETR)
_____ Authorization for Pick Up (on-site only)
_____ Emergency Medical Authorization (on-site only)

*Traducción disponible bajo petición*
*可应要求提供翻译*
*Traduction disponible sur demande*
الترجمة متاحة عند الطلب
*Услуги перевода доступны по запросу*

5500 Market Street Suite 119
Youngstown, OH 44512
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therapy@proaba.org

**Agreement on Service Intensity/Provision**

Part of the effectiveness of applied behavior analysis (ABA) services is based on the service intensity (the number of hours). In ABA, there are generally two service levels-focused and comprehensive ABA. *Focused ABA* focuses treatment on one specific area such as reducing behavior problems or teaching adaptive skills. Focused ABA is usually 10-20 hours per week. *Comprehensive ABA* refers to treatment that targets many domains such as language, communication, reducing problem behavior, increasing adaptive skills, and other developmental skills. Comprehensive ABA is usually 20-35 hours per week.

For ABA to be effective, your child needs to receive the specific hours prescribed in their initial assessment and/or psychological evaluation (if applicable). For instance, if your child's initial assessment recommends 25 hours per week and insurance authorizes this, your child needs to regularly receive these hours to benefit from ABA. Lower hours will be less likely to be effective and frequent reschedules/cancellations/interruptions of services also makes providing this service difficult for Progressive ABA Therapy Group. You involvement in treatment is also critical for therapy gains.

If your child's delivered hours are one quarter (25%) below the expected amount for any 3 week period, Progressive ABA Therapy Group will reach out to discuss barriers to receive services and a plan will be made to address the issues so your child can get their necessary hours. If, after that, hours delivered continue to be below the prescribed amount for a 2-week period, a written 30-day notice will be issues to parents indicating that the child will be

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discharged in 30 days unless the child receives their necessary prescribed treatment. If the issue is not rectified within the 30-day window, the child will be discharged.

Attendance Policy Chart

| Attendance Issue | Plan/Corrective Measure |
|---|---|
| 3 Weeks at 75% or below prescribed hours on treatment plan | Discussion with family on issues and plan created to rectify issues. |
| 2 weeks with continued services 75% or below prescribed hours on treatment plan | 30 day notice issues to parent |
| Attendance issue not resolved within 30 days | Client discharged |

**Appointment Re-scheduling:** Progressive ABA Therapy Group also has an obligation to provide a consistent schedule to employees in addition to consistent therapy for clients. Excessive re-scheduling of appointments, changing of dates and times, no-shows, etc. also impair our ability to provide services. Excessive (more than 4 a month) re-scheduling, changes, and no-shows will also result in a discussion with the family on how to deal with the issue.

**Major Medical Exceptions:** Progressive ABA understands sometimes medical events occur that are out of the family's control. Please reach out to us to discuss any issues or concerns you may have about your child's attendance due to family emergencies and unexpected events.

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**Discharge from Treatment**

Clients will be discharged from Progressive ABA upon any of the following conditions:

a) The family or client requests discharge.
b) The family no-calls/no-shows more than 5 consecutive therapy sessions.
c) The client has reached their discharge criterion as outlined on the treatment plan and no longer require ABA services.
d) The client loses insurance funding for ABA services and does not have sufficient means to fund continued ABA services. In this case, clients would be referred to an appropriate service provider.
e) Client or caregivers do not meet requirements of therapy outlined on the treatment plan which prohibits the delivery of effective services (noncompliance with the treatment plan).
f) The client does not meet the minimal treatment attendance policy outlined above.

All clients who are involuntarily discharged (who did not request one) will be given a 30-day notice of the discharge. For those families who request a discharge or termination of services, services will end on the requested or agreed upon date by the family and Progressive ABA Therapy Group. Appropriate referrals to different care providers will be given at the time of discharge.

**Signatures:** I have read and agree to the above attendance policy. I understand the necessity of my child receiving their prescribed/recommended therapy hours. I have had the opportunity to ask questions about the policy.

_____ _____

Parent Date Witness Date

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**Family Involvement in Applied Behavior Analysis (ABA) Services**

For therapy to work best, the child's parents and caregivers must be active participants in ABA therapy services. Progressive ABA clinical staff expect family participation in development of the child's goals, reviewing and monitoring progress on those goals on a regular basis and review of progress reports (quarterly). Progressive ABA staff will share effective interventions with family members and provide coaching and modeling on how those interventions can be used across the child's day. This ensures that behaviors are responded to in a consistent manner across environments which will help your child to get the most out of their ABA therapy experience. It is a standard requirement for parents to take part in training independent of the patient's funding source. These parent trainings are held 12 times a year. Your child's BCBA will likely set a goal for the number of trainings you should attend as part of your treatment plan. Without participation from parents/caregivers, therapy effectiveness may be reduced. Scheduled parent training sessions that are subject to the same intensity policies above. **For children receiving services in the home or in the community**, a parent or responsible caregiver over the age of 18 is required to be present for the duration of the therapy session. Progressive ABA staff will not be solely responsible for the child's care at any time. In addition, Progressive ABA staff cannot transport your child.

**Progress on Goals:** Your child's supervisor will also set specific parent goals for you. These can include meetings, observations, and ensuring you are able to perform specific tasks relevant to your child's treatment. These goals will be listed on your child's treatment plan. Goals will be rated twice a year (or at each report update) as either **NI** (not initiated), **LP** (limited progress), **AP** (adequate progress), **or M** (mastered). It is our goal and the goal of therapy that you as parents develop the skills necessary

for your child to perform the skills they have learned in therapy at home. Progress on these goals will be reviewed by the supervising BCBA on your case.

**Addressing Lack of Progress:** If your child's supervising BCBA believes that progress on one or more of these goals are lacking after 2 treatment cycles (1 year), they will specifically target this area on the 3rd treatment plan with specific requirements for progress to be made. For instance, if no parent trainings have been attended for the first 2 treatment cycles (1 year), the supervisor will indicate on the next treatment plan that a minimum of 2 must be attended that cycle OR the parent will be required to sign an attestation stating they are unable to meet the required goal and that they understand this likely is a barrier to treatment gains. **If, at any point, the supervising BCBA determines that a lack of progress on these goals or lack of participation on the part of the family is making ABA unsuccessful or countertherapeutic, they may suggest initiating discharge procedures. A treatment team meeting will occur with the family, the technician, the supervising BCBA, and the clinical quality officer to decide about ongoing services.**

**Signatures:** I have read and agree to the above family involvement policy. I understand the necessity of my participation in the ABA services my child is receiving. I have had the opportunity to ask questions about the policy.

_____ _____

Parent Date Witness

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## Client Consent/Assent to Therapy

I consent to the implementation of Applied Behavior Analysis (ABA) therapy services for myself or my child. I am aware that ABA interventions involve changing the client's environment (modifying antecedents and consequences to problem behavior), and using reinforcement to teach new behaviors, among many others. The goal of ABA therapy is to decrease problematic behaviors while increasing appropriate or adaptive behaviors. Clients will learn new skills to help them be successful across environments. It is imperative that parents/caregivers actively participate in therapy to ensure change is maintained across environments and time so that behavior analysis services can be faded.

All interventions that are implemented are evidence-based interventions, meaning there is scientific support for their use. If at any time you do not agree with interventions implemented, please contact your team to address your concerns. You can revoke consent for treatment at any time by notifying Progressive ABA Therapy Group, LLC in writing, however action cannot be revoked for interventions that have already been implemented.

I _____(parent/guardian/client) consent to the implementation of ABA therapy services for _____(child's name) by Progressive ABA Therapy Group, LLC. This release will be in effect for one year from today's date _____ (enter date).

_____Parent/Caregiver/Client Signature

_____Relationship to Client

_____Witness

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**Picture and Video Release**

During the course therapy, pictures or videos of your child may be taken for various reasons. These might include:

- ☐ teaching your child a new skill
- ☐ sharing your child's progress with you
- ☐ trainings within Progressive ABA Therapy Group
- ☐ trainings in the community
- ☐ research/scholarly purposes

By signing this consent form you agree to the use of photographs, videos, and media for any of these purposes. If you would ***not*** like your child's pictures or videos to be shared, you can indicate below. Please understand that your consent or lack thereof, ***does not*** affect your child's services with Progressive ABA Therapy Group, LLC in any way. **This release expires after 1 year from the date of the signature below. You may revoke (terminate) consent previously given by letting us know in writing you no longer wish for your child's picture or video to be taken.**

____ Yes, I agree to the use of photos or videos by Progressive ABA Therapy Group, LLC

List any exceptions below (i.e. I would not like my child's pictures used on the website)

____ No, I do not agree to the use of pictures or videos

_____Parent/Caregiver Name (Printed)

_____Parent/Caregiver Signature

_____Relationship to Child

_____Date

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**Client Financial Responsibility and Consent to Bill Insurance**

Client's Name_____
DOB_____

Parent's/Guardian's Name
_____

***Please read and initial each item below, then sign at the bottom.***

_____I request payment of authorized insurance benefits or subsidies made, on my behalf, payable to Progressive ABA Therapy Group, LLC for any services provided to me or my child. I authorize any holder to release to my insurance company medical information about my child needed to determine benefits or the benefits payable for related services, regulatory compliance, state audit or quality assurance purposes.

_____I understand that Progressive ABA Therapy Group, LLC will submit my insurance claims and that I will be responsible for any deductible, co-payments, co-insurance or client fees at the time services are rendered. I understand that I will receive a monthly statement if my account has a balance due. I understand that Progressive ABA Therapy Group, LLC cannot accept responsibility for collection of my insurance claim or for negotiating a settlement on a disputed claim and that I am responsible for payment of my account. I understand that Progressive ABA Therapy Group may use means such as collection agencies and litigation if I fail to pay my bill for charges that were delivered.

_____Parent/Guardian Signature

_____Date

_____Witness Signature

_____Date

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**Notice about Concerns**

At Progressive ABA Therapy Group, we take your concerns seriously. We have an open-door policy. If you have concerns or would like to make a complaint related to your child's treatment, or treatment team, please notify the Ethics Officer at Progressive ABA Therapy Group (Dr. Kristopher Brown, PsyD, BCBA-D) at your earliest convenience. Progressive ABA Therapy Group provides the contact information below when treatment begins for *transparency* on our part.

***Reporting to the Behavior Analyst Certification Board (BACB)***
The Behavior Analyst Certification Board (BACB) oversees the certification of Board Certified Behavior Analysts (BCBA), Board Certified assistant Behavior Analysts (BCaBA), and Registered Behavior Technicians (RBT). There are ethical and compliance codes that these individuals as professionals follow, which can be located at:

For BCaBAs, BCBAs, and BCBA-Ds:
https://www.bacb.com/wp-content/uploads/2020/11/Ethics-Code-for-Behavior-Analysts-210902.pdf

For RBTs
https://www.bacb.com/wp-content/uploads/2021/07/RBT-Ethics-Code-210615.pdf

Should you feel that a BCBA has violated some part of the code above, you have a right to report the individual to the BACB. If you would like to make a complaint to the BACB, you can log onto their website below:

https://www.bacb.com/

Once on the website, there will be a section labeled Ethics and under that subsection, you will be able to make a report to the BACB. Once you make a report, the BACB will follow up with your report.

Mailing Contact:
Behavior Analyst Certification Board
7950 Shaffer Parkway
Littleton, CO 80127, USA

The State Board of Psychology in Ohio also certifies behavior analysts for practice in Ohio with the certified Ohio behavior analyst (COBA) credential. The state has separate ethics guidelines and practice requirements for practicing ABA in Ohio other than the BACB. These rules of professional conduct can be found here:
https://codes.ohio.gov/ohio-administrative-code/rule-4783-7-01

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If you are concerned with the practice of a COBA or have a complaint, the State Board of Psychology in Ohio can be reached at the following link:

https://psychology.ohio.gov/Enforcement

Mailing Contact:
Vern Riffe Center for Government and the Arts
77 S. High Street, Suite 1830,
Columbus, OH 43215-6108
(614) 466-8808

***Reporting to Behavioral Healthcare Center of Excellence***
Behavioral Healthcare Center of Excellence is our accrediting body for providing applied behavior analysis services. They accredit and oversee the practice of organizations. The accreditation standards for BHCOE can be found here:

https://www.bhcoe.org/standards/

If you have an organizational concern about Progressive ABA Therapy Group's compliance with these standards, a compliance concern can be reported via the following link:

https://bhcoe.org/become-a-bhcoe/report-a-compliance-concern/

Mailing Contact:
Behavioral Health Center of Excellence
8033 Sunset Blvd #1093
Los Angeles, CA 90046
310-627-2746

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**Review of Policies and Procedures**

I have received a copy of the policies and procedures manual from Progressive ABA Therapy Group, LLC dated March 2019. I understand and agree to the policies within.

_____

Name of Parent/Legal Guardian

_____ _____

Signature Date

_____

Relationship to Client

_____

Witness Signature

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## Authorization of Release of Information

Client Name:_____ Date of Birth:_____

I _____(parent/legal guardian), authorize Progressive ABA Therapy Group, LLC to release and exchange protected health information as listed below with the following providers in either written or verbal communication for the purposes of treatment development and coordination of care.

| Provider | Name of Individual Organization | Address and Phone | Purpose | Information to be Shared |
|---|---|---|---|---|
| Pediatrician/Primary Care Physician | | | ☐ Collaborate Care<br>☐ Obtain Information for Assessment<br>☐ Other: _____<br>_____ | ☐ Entire record<br>☐ Treatment plan<br>☐ Behavior plans<br>☐ Progress Notes<br>☐ Assessments |
| Home School District | | | ☐ Collaborate Care<br>☐ Obtain Information for Assessment<br>☐ Other: _____<br>_____ | ☐ Entire record<br>☐ Treatment plan<br>☐ Behavior plans<br>☐ Progress Notes<br>☐ Assessments |
| Speech Language Pathologist (SLP) | | | ☐ Collaborate Care<br>☐ Obtain Information for Assessment<br>☐ Other: _____<br>_____ | ☐ Entire record<br>☐ Treatment plan<br>☐ Behavior plans<br>☐ Progress Notes<br>☐ Assessments |
| Occupational Therapist | | | ☐ Collaborate Care<br>☐ Obtain Information for Assessment<br>☐ Other: _____<br>_____ | ☐ Entire record<br>☐ Treatment plan<br>☐ Behavior plans<br>☐ Progress Notes<br>☐ Assessments |
| Physical Therapist | | | ☐ Collaborate Care<br>☐ Obtain Information for Assessment<br>☐ Other: _____<br>☐ _____ | ☐ Entire record<br>☐ Treatment plan<br>☐ Behavior plans<br>☐ Progress Notes<br>☐ Assessments |
| Other | | | ☐ Collaborate Care<br>☐ Obtain Information for Assessment<br>☐ Other: _____<br>_____ | ☐ Entire record<br>☐ Treatment plan<br>☐ Behavior plans<br>☐ Progress Notes<br>☐ Assessments |

This consent will automatically expire one (1) year after the date of my signature as it appears below. I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____ _____

Parent/Legal Guardian Signature Date Relationship to Client

_____ _____

Witness Signature Date

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**Notice of Privacy Practices**

**Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

**Your Rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**Your Choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

**Our Uses and Disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law

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- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

**Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting our director and privacy officer, Dr. Stephen Flora, at 330-519-2109.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

**Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes

- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease

- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

***These policies are in effect as of March 3, 2019***

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**Notice of Privacy Practices**

I was offered and declined or have received a copy of privacy practices from Progressive ABA Therapy Group, LLC.

Client Name:_____

Parent Legal Guardian Name:_____

Parent/Legal Guardian Signature:_____

Relationship to Client:_____

Date:_____

Witness Signature:_____

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**Intake Questionnaire**

**Client Information**

Client Name: _____ Date of Birth:_____

Address:_____ Family Language: _____

City:_____ State:_____ Zip:_____

**Parent/Legal Guardian Information**

Mother's Name:_____

Address (if different from client's):_____

City:_____ State:_____ Zip:_____

Email:_____ Phone:_____

Mother's Employer:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

Custody Status (circle): Sole custody Joint custody No legal rights

Father's Name:_____

Address (if different from client's):_____

City:_____ State:_____ Zip:_____

Email:_____ Phone:_____

Father's Employer:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

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Custody Status (circle): Sole custody Joint custody No legal rights

Marital status of parents: _____ Married _____ Separated _____ Divorced _____ Single
Was child adopted? _____Yes _____ No

Legal Guardian Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____ Phone:_____

**Siblings or other household members**

Name:_____
Relationship:_____
Age:_____

Name:_____
Relationship:_____
Age:_____

Name:_____
Relationship:_____
Age:_____

Are there any spiritual or cultural variables relevant to your family that you want us to be aware of?

_____
_____
_____

**Billing Information**

**Primary Insurance**
Policy Holder Name: _____
Insurance Carrier: _____
Insurance Policy No.: _____
Insurance Group No.: _____
Policy Holder Date of Birth:_____

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Policy Holder Social Security:_____

Employer Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone #: _____

**Secondary Insurance**
Policy Holder Name: _____
Insurance Carrier: _____
Insurance Policy No.: _____
Insurance Group No.: _____
Policy Holder Date of Birth:_____
Policy Holder Social Security:_____

Employer Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone #: _____

**Medical Information**

Name of pediatrician:_____

Address:_____
City:_____ State:_____ Zip:_____
Phone #:_____
Primary Diagnosis:_____
Diagnosed by?:_____
Child's Age:_____

Secondary Diagnosis:_____
Diagnosed by?:_____
Child's Age:_____

Secondary Diagnosis:_____
Diagnosed by?:_____
Child's Age:_____

Does your child have any allergies? If so what are they?_____

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therapy@proaba.org

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 on medication? No/Yes (please list below)

| Medication | Dose | Frequency | Prescriber |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Does your child have dietary restrictions?_____

**Birth and Developmental History**

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

Were there any complications with the pregnancy?(If yes, please describe the complications below and treatment details) Yes/No _____

Was birth at full term?(If no, please provide details) Yes/No _____

What type of delivery? Spontaneous/ Induced/ Vaginal/ C-Section

Were there any complications during birth?(If yes, please describe the complications below and treatment details) Yes/No _____

What was your child/adolescent's birth weight? _____lbs. _____oz.

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Were there any concerns at birth?(If yes, please describe the concern and treatment details) Yes/No _____

Were there any developmental milestones that your child was delayed in or did not achieve?(If yes, please identify those milestones below) Yes/No _____
_____

**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.
_____
_____
_____

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## Educational Background

School/Educational Placement:_____
Home School District:_____
How long has child attended current educational setting:_____
Does child have an IEP? Yes/No
School Supports Currently Provided:_____
_____
Current Grade:_____

Previous School/Educational Placement:_____
How long?_____
Reason for change in placement:_____

Previous School/Educational Placement:_____
How long?_____
Reason for change in placement:_____

**Additional Services/Therapies**

| Therapy | Provided By? Therapist Name and Company | How often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Emergency Contact Information

Name: _____ Phone Number: _____
Relationship to Child: _____

Name: _____ Phone Number: _____
Relationship to Child: _____

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Progressive ABA THERAPY GROUP

**Authorization for Pick Up**

**Patient's Name:**_____
**Date of Birth:**_____

| **Parent/Guardian Name:** | **Phone:** |
|---|---|
| **Parent/Guardian Name:** | **Phone:** |

List all other individuals who you would allow your child to be released to during pick up.

| **Name** | **Relationship** | **Phone Number** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

_____ _____

Parent Signature Date

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therapy@proaba.org

**Emergency Medical Authorization**

**Patient's Name:**_____
**Date of Birth:**_____

In case of a medical emergency (illness or injury) when your child is in our care please indicate the action you would like our team to take. (Check one)

_____ Progressive ABA **has permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment.

_____ Progressive ABA **does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:

_____
_____
_____

**Child's Pediatrician**:_____

Phone Number:_____

**Preferred Hospital**:_____

Address:_____

_____ _____

Parent Signature Date

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