



# **Enrollment With Therapy Forms**

Dear Parents,

To initiate therapy services all required AFA Academy/HPC enrollment forms **must be submitted** before services can start:

- **Previous evaluations**
- **Most recent progress note**
- **Treatment goals (e.g., IFSP, IEP, treatment plan)**
- **Doctor prescription**
- **For ABA Therapy we need an autism diagnostic report/proof of diagnosis from neurologist or physician.**

Therapists begin with doing either a formal evaluation or informal assessment to evaluate treatment goals and make recommendations for service minutes needed. A therapist is able to carryover current treatment goals and minutes of service from a provider.

Signing the release of information form, the permission form and the health form will allow our staff to collect the required information if preferable.

Thank you and Welcome to the AFA Academy/Howard Park Center



AFA Academy/Howard Park Center  
Enrollment Information

Date: \_\_\_\_\_

Please complete this form and return it to the Academy. This information is necessary to comply with state licensure regulations as well as assist our staff in getting to better know your child.

**BACKGROUND INFORMATION**

Child's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_

Chronological Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Telephone: \_\_\_\_\_

Employer: \_\_\_\_\_

Work phone: \_\_\_\_\_

Hours (days) of work: \_\_\_\_\_

Email (mandatory): \_\_\_\_\_

Cell phone (mandatory): \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Telephone: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Hours (days) of work: \_\_\_\_\_

Email (mandatory): \_\_\_\_\_

Cell phone (mandatory): \_\_\_\_\_

**EMERGENCY CONTACTS: (other than parents or doctor)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Persons authorized to take your child from the Academy.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Who referred you to AFA Academy/Howard Park Center?** \_\_\_\_\_

1. The AFA Academy/HPC has a PTO parent representative. It is common practice for the parent representative to contact and welcome all new Academy families.

**YES**, I want to be contacted. Signature \_\_\_\_\_

**NO**, I do not wish to be contacted Signature \_\_\_\_\_

2. **YES**, I grant permission to AFA Academy/HPC, or persons authorized by it, to photograph my child \_\_\_\_\_ to use such photographs for public relations and operational purposes.

Signature \_\_\_\_\_

**NO**, I do not grant permission for AFA Academy/HPC or persons authorized, to photograph my child.

Signature \_\_\_\_\_

3. Each year we prepare a parent directory which includes the name, address, and telephone number of the parents of each child.

**YES**, I want to be listed. Signature \_\_\_\_\_

**NO**, I do not wish to be listed. Signature \_\_\_\_\_

**Please read the following statements and sign below:**

I hereby release AFA Academy/HPC and those persons operating in its duly authorized behalf, from any responsibility for injury, illness, or accident of my child, considering as long as due care is taken.

I hereby exonerate AFA Academy/HPC from any damages the child may cause to any person or property while he/she is in the care of the Center.

I understand that my child may be released at any time during the program by the director if in the director's judgment, the child is not making satisfactory progress or, if it is determined that the child has hampered the safety, welfare, health, of other children or staff.

I have received and reviewed the enclosed Parent Handbook containing HPC policies including: program descriptions, mission statement, control and discipline, human rights, grievance procedures, discharge and transfer, and health pertaining to my child's enrollment at AFA Academy/HPC.

Upon admission of my child \_\_\_\_\_ to AFA Academy/HPC I hereby give consent to person duly authorized to act on its behalf, the unqualified right and permission to use their discretion in obtaining emergency medical and hospital care at my expense. In the event that I cannot be reached, the Center may arrange for a physician/hospital to secure proper treatment, order treatment, order injection, anesthesia, or surgery for my child.

Signature \_\_\_\_\_

Please attach a recent picture of your child. It is **MANDATED** by the state that every child's file contain a photo. Thank you.

Child's name: \_\_\_\_\_

Date: \_\_\_\_\_

Please use the remainder of this page to write a short biography of your child. Include things you enjoy doing together, personality, goals you would like him/her to accomplish, areas of concern, or anything else you feel comfortable in sharing.

Introducing: \_\_\_\_\_

**CONSENT FOR RELEASE OF INFORMATION FORM**

I authorize the release of any and all reports and evaluations, as well as verbal communications regarding my child to  
**Howard Park Center, 16375 Pierside Lane, Wildwood, MO 63040 (636-405-2701, Fax 636-422-1223)**

**Student:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Pediatrician/Doctor:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**School District Personnel:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Case Manager:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Specialist/Doctor (i.e. Neurologist):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Private Speech Therapist:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Private OT:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Private PT:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**PRIVATE BCBA:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

If you need more room please write on the back or include another sheet of paper. (Cardiologist, Urologist, Nutritionist etc.)



Date: \_\_\_\_\_

Re: \_\_\_\_\_

Dear Dr. \_\_\_\_\_

I am pleased that AFA Academy/Howard Park Center can offer pediatric therapies to your patient.

AFA Academy/Howard Park Center is a private non-profit facility designed to meet the needs of infants and preschoolers with mild, moderate or severe mental and/or physical developmental problems and to provide support to their families. We are licensed by the Department of Mental Health and are a vendor for Medicaid. In order for your patient to receive services at our Center, I must have a referral from you. Please complete the attached prescription form and return it to me.

If you have any questions regarding this referral, please contact me at (636) 405-2701. Thank you for your cooperation.

Sincerely,

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**RELEASE**

Permission granted to send a referral/prescription form to the physician named below:

\_\_\_\_\_

I understand that there must be a physician's referral form signed prior to my child receiving therapy services at AFA Academy/Howard Park Center.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date



## PRESCRIPTION FORM FOR THERAPY

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

DX: \_\_\_\_\_

### Please check the recommended services:

\_\_\_\_\_ Physical Therapy (including Aqua Therapy) \_\_\_\_\_ minutes per week

\_\_\_\_\_ Occupational Therapy (including Aqua Therapy) \_\_\_\_\_ minutes per week

\_\_\_\_\_ Speech/Language Therapy \_\_\_\_\_ minutes per week

\_\_\_\_\_ ABA (Applied Behavior Analysis) as medically necessary 28 hours per week

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE NOTE: PRESCRIPTIONS ARE VALID  
FOR 12 MONTHS FROM THE ABOVE DATE.**





AFA Academy/Howard Park Center Health Form



16375 Pierside Lane, Wildwood, MO 63040 (636-405-2701, Fax 636-422-1223)

I authorize AFA Academy/Howard Park Center to contact my child's doctors regarding medical information.

Parent or Guardian (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Fax #: \_\_\_\_\_

This form must be completed in its entirety prior to child receiving services from AFAA/Howard Park Center staff and/or before entering our program. We can fax this form to your doctor if you fill out the above information.

DATE OF EXAMINATION: \_\_\_\_\_

GENERAL INFORMATION

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Disability (if any): \_\_\_\_\_

Etiology of disability: \_\_\_\_\_

SENSES/CONCERNS

Vision Right \_\_\_\_\_ Left \_\_\_\_\_ Glasses: [ ] Yes [ ] No
Hearing Right \_\_\_\_\_ Left \_\_\_\_\_ Aid: [ ] Yes [ ] No
Tactile: [ ] Yes [ ] No If yes, explain: \_\_\_\_\_
Olfactory: [ ] Yes [ ] No If yes, explain: \_\_\_\_\_
Gustatory: [ ] Yes [ ] No If yes, explain: \_\_\_\_\_

Please list any health concerns/ limitations and any special instructions that our staff needs to be aware of:

Table with 2 columns: Health concerns/Limitations, Special Instructions

ALLERGIES

Please list all allergies and reactions/treatment

Table with 2 columns: Allergy, Reaction/Treatment

MEDICATIONS: PLEASE ATTACH A PRESCRIPTION FOR ANY MEDICATION, OVER THE COUNTER OR PRESCRIPTION THAT IS TO BE ADMINISTERED AT SCHOOL. IF WE DO NOT HAVE A SCRIPT, WE ARE NOT ALLOWED TO ADMINISTER ANY MEDICATION.

PLEASE ATTACH A COPY OF CHILD'S IMMUNIZATION RECORD.

**GENERAL CONCERNS**

In my professional opinion, this child is free from contagious disease.  Yes  No

Any congenital virus?  Yes  No

If yes, what Virus? (Cytomegalovirus, Herpes, etc) \_\_\_\_\_

Contagious?  Yes  No

Precautions needed due to virus. \_\_\_\_\_

**TB skin or blood test:** Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines.  No test needed  Test performed

Skin test: Date read: \_\_\_\_\_ Result:  Positive  Negative mm \_\_\_\_\_

Blood test: Date reported: \_\_\_\_\_ Result:  Positive  Negative value \_\_\_\_\_

List any physical limitations of the child or activities he/she is NOT recommended to participate in, i.e., swimming, etc. \_\_\_\_\_

List any concerns you may have regarding the handling or programming of this child (NOTE: This is extremely beneficial to our center). \_\_\_\_\_  
\_\_\_\_\_

**Physician's Signature \*** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**\* Please no stamps, signature required.**

Please return this form to:

AFA Academy/Howard Park Center  
16375 Pierside Lane  
Wildwood, MO 63040

or fax to 636-422-1223.



INTAKE FORM

Directions: This form is used to understand history and concerns of the client and his/her family and is a part of the requirements for some insurance companies. Please complete the intake form to the best of your ability. If there is an item you do not know you can seem relevant to young children however give your best answer. Thank you for your time!

DATE: \_\_\_\_\_

PATIENT INFORMATION:

LEARNER: \_\_\_\_\_ DOB: \_\_\_\_\_

GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Reason for Admission: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis and Codes: \_\_\_\_\_

I have submitted the results of the evaluation for the diagnosis of autism:  YES  NO

I have a Doctor's Script for ABA services:  YES  NO

Diagnosis by: \_\_\_\_\_ Date: \_\_\_\_\_ ICD-9: \_\_\_\_\_

Other Agencies Involved: \_\_\_\_\_

FAMILY INVOLVEMENT & SUPPORT (e.g., home life, community services/supports)

Briefly describe what life at home is like (lives with....daily schedule, etc.): \_\_\_\_\_

\_\_\_\_\_

Major Life Changes: \_\_\_\_\_

\_\_\_\_\_

Family has current Support and Training From: \_\_\_\_\_

Any Barriers to Generalization of Strategies to Home: \_\_\_\_\_

Any pertinent legal issues of client or family: \_\_\_\_\_

Community services family has accessed and have available: \_\_\_\_\_

\_\_\_\_\_

Needed Resources: \_\_\_\_\_

Need for Discharge & Transition Planning: Discharge:  Yes  No Transition:  Yes  No

RISK ASSESSMENT (client and/or family members – please note who)

Risk/History of neglect:  Yes  No If yes please describe: \_\_\_\_\_

Risk/History of abuse:  Yes  No If yes please describe: \_\_\_\_\_

Risk of suicide:  Yes  No If yes please describe: \_\_\_\_\_

Risk of homicide:  Yes  No If yes please describe: \_\_\_\_\_

Risk of substance abuse (alcohol, nicotine, illicit drugs) patient/family:  Yes  No If yes please describe: \_\_\_\_\_

-Risk of sexual concerns:  Yes  No If yes please describe: \_\_\_\_\_

Risk to self/others:  Yes  No If yes please describe: \_\_\_\_\_

MEDICAL HISTORY

HISTORY: \_\_\_\_\_

Any concerns with client or family medical history?  Yes  No If yes please describe: \_\_\_\_\_

Dates previous/current MEDICAL interventions: \_\_\_\_\_

Test - Lab results: \_\_\_\_\_

Location/Provider: \_\_\_\_\_

Treatment/Response: \_\_\_\_\_

Drug allergies/food allergies/adverse reaction: \_\_\_\_\_

Medications	Dose	Frequency	Indication	Compliance
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**DEVELOPMENTAL AND PHYSICAL HISTORY (progress of clients developmental stages, gross motor/fine motor skills)**

Prenatal/Perinatal history or events: \_\_\_\_\_

Developmental history/concerns: \_\_\_\_\_

Dates previous/current DEVELOPMENTAL interventions or testing (dev therapy, OT, PT, ABA-vbmapp/ablls): \_\_\_\_\_

Location/Provider: \_\_\_\_\_

Treatment/Response: \_\_\_\_\_

Communication/Collaboration w/providers: \_\_\_\_\_

**GROSS MOTOR SKILLS**

AGE AT WHICH: \_\_\_\_\_ sat up w/o support \_\_\_\_\_ crawl \_\_\_\_\_ walk \_\_\_\_\_ made first 5 words \_\_\_\_\_ Communicate 5 two-word phrases

- CURRENTLY can:
- walk/run and walk up steps (w or w/o asst)
  - walks around objects on floor
  - protects self with hands when falling
  - get on and off things (chairs, ride-ons, couch, bed, car seat)
  - uses playground materials

**FINE MOTOR SKILLS**

- CURRENT SKILLS (check all that apply):
- Play with cause and effect toys, push many buttons
  - Cleans up
  - Roll ball back and forth to others 3 x
  - snip/cut
  - IN; sorter, pegs, puzzle pieces
  - ON: Ring sorter, stack blocks, duplos/legos
  - Watches you and imitates you in play
  - PUSH/PULL: play-doh, push/pull toys, pop beads, string beads
  - Takes turns, plays together taking turns with others
  - Pretend play toward self; pretend to eat, dress up clothes on, answers pretend phone
  - Scribble/draw/copy lines/shapes
  - Plays with objects as intended/function/stays with play for long time
  - tolerate messy play and various tactile mediums

History: \_\_\_\_\_

Dates previous/current SOCIAL interventions and testing (ADOS): \_\_\_\_\_

Location/Provider: \_\_\_\_\_

Treatment and Responses: \_\_\_\_\_

Communication/collaboration with providers: \_\_\_\_\_

**CURRENT SKILLS (check all that apply):**

- Make regular eye contact with adults
- Makes regular eye contact with peers
- stays in a silly game for 2 minutes
- Enjoys affection (hugs, kisses)
- Looks when name is called
- Turns eyes toward loud noises
- Follows simple directions
- Enjoys playing silly games together (e.g.; peek-a-boo)
- Participates in 10 silly games
- Makes eye contact w/pointing when wants/to ask for something
- Makes eye contact w/pointing to show you/non verbally label things and share enjoyment
- Shifts eye contact between you and an object frequently to show and share enjoyment
- When named points to/gets items
- Vocally labels items
- Vocally fills in words to songs/books

COMMUNICATES FOR ITEMS BY:  scream/cry to get  pull you to it  gestures-points to it

picture/signs  says word to get

COMMUNICATES FOR HELP/OPEN BY:  scream/cry to get it  gestures-offer it to you  sign  say word to get help-open

COMMUNICATES TO PROTEST:  scream/cry  gestures-shakes head no  picture or sign  says no

COMMUNICATES FOR BREAK/END:  scream/cry  picture or sign  says "done, all done, break"

COMMUNICATES FOR YOUR ATTENTION:  scream/cry  gesture-wave, grab you, gets in your lap, gets in front of your

picture/sign  says hi, mama, dada, hug, kiss, cuddle

**COGNITIVE/ACADEMIC/EDUCATIONAL-SCHOOL HISTORY (clients)**

History: \_\_\_\_\_

Mental Status: please list any concerns with clients affect, speech, mood, thought content, judgment, insight, attention, concentration, memory, impulse control: \_\_\_\_\_

Dates previous/current EDUCATIONAL interventions or testing (mullen/bailey/wisc): \_\_\_\_\_

Location/Provider: \_\_\_\_\_

Treatment/response: \_\_\_\_\_

Communication/collaboration w/providers: \_\_\_\_\_

**CURRENT SKILLS (check all that apply)**

- Match identical items (e.g., when playing grabs two of the same apples)
- Matches identical pictures (e.g., can match dog piece to dog in a puzzle), match pics to a book
- Matches by color (e.g., accurate with colored circles to correct color on a sorter)
- Selects when named or vocally labels 8 of each colors/shapes
- Selects when named or vocally labels letters/numbers

**ADAPTIVE BEHAVIOR HISTORY (clients daily living skills-dressing, eating, hygiene/grooming, chores)**

History: \_\_\_\_\_

Dates previous/current interventions or testing (e.g., vineland II, adaptive behavior scale): \_\_\_\_\_

Location/provider: \_\_\_\_\_

Treatment & Response: \_\_\_\_\_

Communication/collaboration w/providers: \_\_\_\_\_

**CURRENT SKILLS** (check all that apply):

**TOILETING:**

- takes diaper off
- urinates in toilet
- pull up pants
- turns on water
- rinses hands
- dries hands
- when cued to go potty locates toilet
- has bowel movement in toilet
- flushes
- gets soap
- turns off water
- throws towel away
- push down pants
- wipes
- goes to sink
- rubs hands
- gets paper towel

**DRESSING (ON):**

- None
- Shoes
- socks
- pants
- shirt
- coat
- diaper/underwear
- snap
- zip
- button
- tie

**DRESSING (OFF)**

- none
- shoes
- socks
- pants
- shirt
- coat
- diaper/underwear
- unsnap
- unzip
- unbutton
- untie

**HYGIENE/GROOMING**

- none
- brushes hair
- wash face
- wipes nose
- wash hands
- wipes face/hands
- wash hair
- tissue in trash
- wash other parts

**WHEN CUED TO BRUSH TEETH:**

- gets toothbrush
- brushes 1 minute
- gets toothpaste
- rinses/spits
- puts paste on brush
- rinse brush
- brushes for 10 seconds
- put items away

**FEEDING:**

- finger feeds
- uses a spoon
- drinks from a sippy cup
- cut food
- highchair
- uses a spoon with prompts
- uses a fork
- drinks from a an open cup
- sits and stays at table for meal
- chair
- uses a fork with prompts
- drinks from a bottle
- drinks from a straw
- sits in booster seat
- on your lap
- my child does not sit to eat

**EATING:**

- LIKES FOOD:**  frozen  cold  cool  hot  warm  room temperature

- LIKES FOOD TEXTURE TO BE:**  melt-able  lumpy  crunchy  fork mashed  strained  finger food  pureed-baby food  table foods

- EATS:**  raw fruits  grain  juice  food combination (soup/casseroles)
- raw vegetables  snack  water
- cooked vegetables  meats  cheese
- crunchy  milk  yogurt

**BEHAVIORAL/ PSYCHIATRIC / PSYCHOLOGICAL / EMOTIONAL HISTORY (client and/or family - please note who)**

HISTORY: \_\_\_\_\_

Dates previous/current interventions or testing (child behavior checklist, BASC): \_\_\_\_\_

Location/provider: \_\_\_\_\_

Treatment & Response: \_\_\_\_\_

Communication/collaboration w/providers: \_\_\_\_\_

**CURRENT INAPPROPRIATE BEHAVIORS:** please check & write on the line how many times per WEEK it occurs (e.g., 5, 5-10, 10-20, too much to count)

\_\_\_\_\_ Inappropriate verbal behavior such as loud vocalizations and/or inappropriate vocalizations or statements, (e.g., swearing, threat of harm statements, screaming, protesting, statements of negativity, foul language)

\_\_\_\_\_ Eloping/escaping- any attempt or success at leaving seat/ situation by butt off chair or walking/ running in other direction, when not directed. May or may not include dropping to the ground in which child's bottom or knees contacts the ground. Running away

\_\_\_\_\_ Aggression OR Property disturbance (PD)- any attempt or success at hitting, kicking, punching, biting, scratching, pinching, pulling hair, spitting, ripping/tearing, throwing, directed at others or materials/property.

\_\_\_\_\_ Self-Injury- (SIB) any attempt or success at hitting, punching, biting, scratching, pulling hair, pinching/picking/poking, directed at self. Results in injury to client (bruises, scratches, hair loss, blood, wounds)

\_\_\_\_\_ Pica- putting inedible and/or non-food items past plane of lips and in mouth and/or ingesting these items.

\_\_\_\_\_ Fear responses- difficulty tolerating unpleasant / undesired stimuli often including one or many of the abovementioned target behaviors (e.g., loud vocalizations/protests and escape behavior in the presence of loud noises, touch/tactile sensations, places/activities- mall/doctor-exam or shot/ dentist- cleaning/barber-haircut.

\_\_\_\_\_ Non- compliance and/or non-responding (failing to respond within 10 seconds of a direction). May include vocal protesting

\_\_\_\_\_ Food refusal/selectivity- refusing to eat certain foods (via verbal protest/ motor protests such as hit utensil/spit food out of mouth beyond plane of lips).

\_\_\_\_\_ Stereotypic motor movements Any time the learner engages in a "off task" behavior more than 2 times within the period of 2 minutes. May include a repetitive motor movement that does not pertain to the on-going activity/out of context. (e.g., spin objects, flap hands/strings/toys, hand-to -head/mouth, flick hands against items, etc.) or Rigid PATTERNS of behavior or routines of preferred interaction with the environment that when blocked triggers problem behaviors (e.g., repetitive opening/closing, straightening things, doing things in a certain order, not tolerate adult control of preferred items

\_\_\_\_\_ Other unsafe behavior or inappropriate behavior: \_\_\_\_\_

**PRESENTING CONCERNS**

SPEECH/LANGUAGE/COMMUNICATION: \_\_\_\_\_

SOCIAL: \_\_\_\_\_

SENSORY: \_\_\_\_\_

COGNITIVE: \_\_\_\_\_

HEALTH/PHYSICAL/BEHAVIOR/MEDICALLY STABILITY: \_\_\_\_\_

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ADAPTIVE FUNCTIONING WHEN COMPARED TO DEVELOPMENTALLY EXPECTED FUNCTIONING: \_\_\_\_\_

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**ASSESSMENT**

Although HPC offers assessment for Applied Behavior Analysis, Occupational therapy, Physical Therapy, and Speech Language Therapy, Assessments of vocational skills and intervention, chemical dependency, legal needs, spiritual and cultural needs are currently not offered

Please list any spiritual needs or issues that may impact delivery of services or treatment. \_\_\_\_\_

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Please list any cultural needs or issues that may impact delivery of services or treatment. \_\_\_\_\_

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Please list any legal or chemical dependency needs or issues that may impact delivery of services or treatment. \_\_\_\_\_

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Level of current treatment services & expected completion date is: \_\_\_\_\_

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Thank you again for your time!!!!  
Sincerely,  
AFA Academy/HPC Team



**Insurance Information: Mandatory**

It is AFA Academy/HPC's policy that we will bill a family's private insurance policy for the services given to their child but only after a parent has given us permission to do so.

Please initial here to give AFA Academy/HPC permission to bill your insurance company. \_\_\_\_\_

Please initial here to give AFA Academy/HPC permission to bill you the parent pay rate for OT, PT, ST at \$75.00 per session, with a session maximum of 1 hour, in lieu of billing. ABA Para rate will be billed at \$45 per hour, ABA Lead at \$75 per hour and Board Certified Behavior Analyst will be billed at \$100 per hour. \_\_\_\_\_

It is also AFA Academy/HPC's policy to make a claim to the insurance company the month after the services were rendered. If a claim is rejected for any reason, AFA Academy/HPC staff will comply with the requests from the insurance company and resubmit the claim. If after the second attempt, the claim is rejected, no further claims will be submitted to the insurance company and parents will then be responsible for the services rendered. Please note, OT,PT and ST are a separate service from ABA, and will be billed separately should a family wish to have those therapy services.

Learner's therapy slot can be held for 2 weeks pending appeals. If at that point insurance has not authorized services, the learner will be put on the wait list until service is authorized.

Please sign here that you have read and understand this policy. \_\_\_\_\_  
Parent/Guardian signature

We request a copy of all insurance cards (front and back) as well as Medicaid, if applicable. In addition, please complete:

**Primary insurance:**

Company name: \_\_\_\_\_  
Company address: \_\_\_\_\_  
Company phone: \_\_\_\_\_  
Policy holder's full name: \_\_\_\_\_  
Policy holder's date of birth: \_\_\_\_\_  
Child's name: \_\_\_\_\_  
Child's date of birth: \_\_\_\_\_  
Policy number: \_\_\_\_\_  
Group number: \_\_\_\_\_

**Secondary insurance:**

Company name: \_\_\_\_\_  
Company address: \_\_\_\_\_  
Company phone: \_\_\_\_\_  
Policy holder's full name: \_\_\_\_\_  
Policy holder's date of birth: \_\_\_\_\_  
Child's name: \_\_\_\_\_  
Child's date of birth: \_\_\_\_\_  
Policy number: \_\_\_\_\_  
Group number: \_\_\_\_\_

**Medicaid:**

Name on card: \_\_\_\_\_  
State issued: \_\_\_\_\_  
Medicaid number: \_\_\_\_\_  
Medicaid phone: \_\_\_\_\_

## Notice of Privacy Practices

I have read the attached Notice of Privacy Practices brochure.  
I authorize the AFA Academy/Howard Park Center to use  
and disclose my child's personal medical information as outlined.

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Print Child's Name

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Parent's Signature

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Date

(I have kept the attached copy of AFA Academy/HPC Privacy Practice for my personal files.)

## **Notice of Privacy Practices (KEEP FOR YOUR RECORDS)**

This Notice describes how medical information about your child may be used and disclosed and how you can get access to this information. Please review carefully. This Notice is intended to inform you about our practices related to your child's medical records. It will explain how AFAA/HPC may use and disclose medical information, our obligations related to the use and disclosure of medical information, and your rights related to any medical information that we have about your child.

We have listed some of the reasons why we might use or disclose medical information, with some examples. Not every potential use or disclosure is discussed, but all of the ways that we are allowed to use and disclose information falls into one of the categories below.

### **Use & Disclosure of Medical Information:**

**For Treatment:** To provide your child with medical treatment or services, we may need to use or disclose information about your child to personnel involved in the treatment. For example, a therapist may need to consult with another therapist regarding your child's condition while providing care.

**For Payment:** We may use and disclose your child's medical information to bill and receive payment for the treatment received. For example, we may use or disclose medical information to your insurance company about a service received from AFAA/HPC so that your insurance company can pay us or reimburse you for the service.

**For Health Care Operations:** We can use and disclose medical information about your child for our operations. For example, we may use or disclose medical information to evaluate our staff's performance in caring for your child.

### **Uses & Disclosure of Medical Information that Do Not Require Your Authorization:**

We can use or disclose health information about your child without your authorization when there is an emergency, or when we are required by law to use or disclose certain information. We may use or disclose health information without your authorization in any of the following circumstances:

- When it is required by federal, state or other law;
- When it is needed for public health activities;
- When reporting information about victims of abuse, neglect or domestic violence;
- When disclosing information for the purpose of health oversight activities;
- When disclosing information for judicial and administrative proceedings;
- When disclosing information for law enforcement purposes;
- When we believe in good faith that the disclosure is necessary to avert a serious health or safety threat;
- When disclosure is necessary for specialized government functions;
- When disclosing is necessary to comply with worker's compensation laws or purposes.

### **Planned Uses or Disclosures**

We may use or disclose your health information for any of the purposes described in this section unless you affirmatively object to or otherwise restrict a particular release. You may direct your objections or restrictions in writing to the Director of AFAA/HPC.

- We may use or disclose your health information to contact you and remind you about any appointment for treatment.
- We may use or disclose your health information to provide you with information about or recommendations of possible treatment options or alternatives that may interest you.
- We may use demographic information about you including your name, address, and phone number to contact you and to seek private support for the Howard Park Center. If you do not wish for your information to be used for such purposes, please contact the Director.
- We may not release health information to a friend and/or family member who is involved in your child's care. We cannot tell your family and/or friend that you are using HPC for treatment or services. We can not give this information to someone who will help or is helping to pay for your care.
- We cannot disclose health information to a public or private entity that is authorized by law or its charter to assist in disaster relief efforts (e.g., the American Red Cross).

### **Other Uses or Disclosures**

If you provide us written authorization to use or disclose your health information, you can change your mind and revoke your authorization at any time in writing. If you revoke your authorization, we will no longer use or disclose the information, but we will not be able to take back any disclosures that we have already made.

### **Your Rights with Respect to Health Information**

- Right to inspect and copy your health information. You have the right to inspect and copy your health information, with certain exceptions. If you request copies of information, we may charge a fee for costs associated with your request, including the cost of copies, mailing or other supplies.
- Right to request information in certain form and location. You have the right to request health information in a certain form or at a specific location. For instance, you can request that we not contact you at work. The request must tell us how and/or where you want to receive information. We will accommodate reasonable requests.
- Right to request amendment to health information. You have a right to request that your child's health information be amended if you believe that it is incorrect or incomplete. You must provide the reason that you want the amendment added to the health information. Your request must be in writing.
- Right to an accounting of disclosures. You have the right to receive any accounting of disclosures of medical information that we have made, with some exceptions. You have the right to receive one (1) free accounting every twelve (12) month period; we may charge a reasonable fee for the costs of providing that list.
- Right to request restrictions. You have the right to request that we restrict any use or disclosure of health information. If we agree to your restriction, we will comply with your request. For example, a patient who does not want his physician to share health information with other physicians involved in his care may request to restrict such disclosure. We are not required to accept any restriction that you request.

Federal law gives all patients a right to a paper copy of this Notice. If you have agreed to receive this Notice in another form, you can still request a paper copy of this Notice.

### **Privacy Complaints**

If you have any questions about the consent of this Notice, or if you need to contact someone regarding the privacy of your health information, please contact the Director of AFAA/HPC.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint with either HPC or the U.S. Department of Health and Human Services.

### **Changes to this Notice**

We reserve the right to change or modify the information contained in this Notice. Any changes that we make will comply with appropriate federal, state or other laws. AFAA/HPC will provide its patients with the most recent copy of this Notice and post this version at our facility.