Client Intake Form

This form is to be completed by the Parent/Guardian of the client of Optimal Outcomes, LLC prior to the initial consultation visit.

Parent/Guardian Information

Parent/Guardian 1 Name: (First, Middle, Last) _____

Parent/Guardian 1 Email: _____

Parent/Guardian 1 Phone #: _____ - _____ - _____

Parent/Guardian 2 Name: (First, Middle, Last) _____

Parent/Guardian 2 Email: _____

Parent/Guardian 2 Phone #: _____ - _____ - _____

Primary Street Address: _____

(Street number) **(City, State, Zip)**

Marital Status:

Child's Information

Child's Name (First, Middle, Last): _____

Child's Date of Birth: _____ / _____ / _____

Child's Social Security: _____ - _____ - _____

Primary Street Address: _____

(Street number) **(City, State, Zip)**

Insurance Information A copy of the insurance card will be required at the time of initial visit

Name of Insurance Company: _____

Name of Policyholder: _____

Social Security # of Policy Holder: _____

DOB of Policy Holder: _____

Insurance Address: _____

Phone Number: _____

Member ID: _____ Group ID: _____

Medical Information

Name of physician: _____

Physician address: _____

Physician phone: (____)_____

Does your child have any current health condition? If so, please explain below

_____

_____

Please list any medications that your child is currently taking.

Medication Dosage Frequency Side effects

Does your child currently have any diagnoses? If so, please state below.

_____

_____

_____

*Required for insurance coverage

Diagnosing physician: _____

Date of Diagnosis: _____

Diagnosis Code: _____

Educational Information

Does your child attend school? If so, please complete the information below.

Name of school: _____

Classroom Type: _____

Teacher/Grade: _____

Address: _____

School Phone number: (____)_____

Current/Previous Therapy Provider Information (please attach most recent evaluations):

Behavioral Provider Name: _____

Contact Name/Phone:

_____

Dates of Service:

_____

Please state the therapy outcomes:

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Speech Therapy Provider Name: _____

Contact Name/Phone:

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Dates of Service:

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Please state the therapy outcomes:

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Occupational Therapy Provider Name: _____

Contact Name/Phone:

_____

Dates of Service:

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Please state the therapy outcomes:

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Other Therapy Provider Name: _____

Contact Name/Phone:

_____

Dates of Service:

_____

Please state the therapy outcomes:

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Child's Current Behaviors and Expected Outcomes:

Please provide detail regarding the concerns of your child's development, if any.

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Please describe any problem behaviors or interfering behaviors of concern.

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Please state the expectations/goals that you have for your child while engaging in a behavioral program:

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Please list any other information that may be helpful while assessing and/or conducting therapy with your child:

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Referred by: _____

*Please attach any assessments or evaluations that may aid in developing your child's

PROGRAM OR BEHAVIORAL INTERVENTIONS

Verbal Behavior (ABA/VB) Program Information

Description

Our Verbal Behavior program is designed for children who have autism or a similar disorder or children who exhibit skills deficit. It includes 1:1 therapy from an RBT, BCaBA, or BCBA for a minimum of 4 hours per week to teach skills such as language/communication, self-help skills, social skills, academic and compliance skills.

Intake Procedure: An initial assessment is conducted (VB-MAPP) with you and your child which takes approximately 3 hours depending on the skill level of the child. Based on the information received from the assessment, the following programs may be recommended:

• 4-30 hours per week of individualized instruction by an RBT, BCaBA, or BCBA

• Weekly program review and maintenance by BCBA or BCaBA

• Biweekly or Monthly Supervision of program by BCBA or BCaBA

• Face-to-face/phone consult per month (at the clients request)

• Biweekly or Monthly program updates by BCBA or BCaBA

Behavior Reduction Program Information

Description:

Our behavior reduction program is designed for children who may or may not have a diagnosis but who engage in disruptive behavior in the home, school or community settings. This program focuses on teaching parents, teachers and other caregivers how to effectively decrease a child's disruptive behavior and increase compliance and other appropriate behaviors.

Intake Procedure

A Functional Assessment Interview is conducted with the caregiver/school staff in order to collect information regarding the behaviors of concern.

Behavior Reduction Program

• Initial Behavior Interview, Motivation Assessment Scale, and Functional Assessment Screening Tool are conducted with family and/or school staff at our office

• Records review

• Observation(s) of problem behavior in natural environment

• Review data collected by caregiver and/or school staff

• Develop formal written recommendations

• Review recommendations with caregiver and/or school staff

• Follow-up visit(s) to model recommended interventions

Additional Services Offered

IEP Support and Development

Behavioral Consulting staff are available to attend IEP meetings with the caregivers of our current clients in order to ensure goals and services are appropriate and in the child's best interest.

It is recommended that a draft copy of the IEP be obtained at least 3-5 days prior to the IEP meeting in order for our staff to review the goals and discuss changes, modifications, and priorities with the family.

Client Services Agreement

This Agreement, effective on the date that the last party signs the Agreement (the "Effective Date"), is by and between Optimal Outcomes, LLC and the client. Optimal Outcomes, LLC and Client are referred to collectively as the "Parties". The Parties agree as follows:

1. Term of Agreement

This Agreement remains in effect from the Effective Date until either party terminates this Agreement by giving 14 days written notice.

2. Services Provided by BCOTB

Client agrees to cooperate with Optimal Outcomes' efforts to provide services to Client's child and the Client's family and Client agrees to participate in the treatment process and will follow through with any interventions recommended by Optimal Outcomes. Optimal Outcomes will supervise and monitor services provided to Client and/or Client's child by individual therapists and consultants who are employed by Optimal Outcomes. Client acknowledges that Optimal Outcomes shall have exclusive responsibility and authority to make all professional judgments and decisions with reference to the services rendered to Client or Client's child.

Client acknowledges that, if Client's child is participating in a 1:1 treatment program (Verbal Behavior Program) with Optimal Outcomes, a minimum of monthly to biweekly supervision is required to properly supervise the program, to observe Client's child engaging in the recommended program, and to implement changes to the Child's program. This process typically takes 1 to 2 hours and a therapist on the child's team must also be in attendance.

3. Payment for Services. Clients without a current insurance authorization, who are paying privately for services, agree to pay for all services bimonthly.

A. Insurance Policies

If a current insurance authorization is on file, Client authorizes Optimal Outcomes to file insurance claims on Client's behalf. Client also agrees to pay all co-payments, deductibles and fees for co-insurance bimonthly in which therapy is provided.

Even though Optimal Outcomes will verify eligibility and benefits, Clients should be advised that a Statement of Benefits provided by an insurance carrier is never a guarantee of payment. In some cases, certain claims may be denied as "non-covered" services. In which case, Client agrees to pay for all previously provided "non-covered" services. Client also acknowledges that Optimal Outcomes may temporarily suspend services until payment has been received.

B. Billed Services

Optimal Outcomes bills per quarter hour for all services provided. Rates may be adjusted at any time without prior notice. In addition to assessments and direct therapy services, the following additional services may be billed in order to ensure optimal outcomes for your child's progress:

- Monthly Program Updates
- Therapist Supervision
- Review of Data and Graphs
- Development of Program Materials
- Parent Meetings and Training
- School Meetings and Consultation
- Behavior Plan Development
- Reports Required by Insurance Carriers
- Travel Fees, when applicable
- Telephone Consultations