APPLIED BEHAVIOR CENTER for Autism

Exceptional Therapy for Exceptional Children

113 West Chapman Road. Oviedo, FL. 32765
1450 Daniels Road. Winter Garden, FL. 32787
111 S. Alabama Ave. DeLand, FL. 32724

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INCOMPLETE APPLICATIONS AND / OR APPLICATIONS SUBMITTED WITHOUT AN ATTACHED DIAGNOSIS REPORT CANNOT BE PROCESSED

Placement Options (*please select all those that apply*)

- ☐ **FULL TIME IN-CENTER PLACEMENT OVIEDO LOCATION**
- ☐ **FULL TIME IN-CENTER PLACEMENT WINTER GARDEN LOCATION**
- ☐ **FULL TIME IN-CENTER PLACEMENT DELAND LOCATION**
- ☐ **HOURLY IN-CENTER THERAPY (DEPENDING ON AVAILABILITY OF SPACE)**
- ☐ **HOURLY IN-HOME THERAPY**
- ☐ **SUMMER SESSION (CIRCLE LOCATION) OVIEDO WINTER GARDEN DELAND**

How did you hear about Applied Behavior Center for Autism, Inc.(check one below/fill in as requested)

Doctor(name)_____ Brochure(location)_____ Internet___ Facebook___Friend___

Insurance referral___Bright Feats___CARD___McKay site___Flyer____Other(specify)_____

Child Information

Name (Last, First)	**Age**	**DOB**	**Sex**

Mailing Address	**City**	**State**	**Zip Code**

Primary Diagnosis **Diagnosis Code:**	**Date Diagnosed:**	**Child's Age at Time of Diagnosis:**

Name of School Attending	**Matrix Score**	**School County**	**Social Security #**

Allergies	**Current Medications:**
Current / Previous Therapies Tried	**How Does Client Communicate:(Circle)** PECS Pointing Gesturing Verbal

Toilet Trained: **(circle one)** YES NO YES (BUT NOT OVERNIGHT)	**Aggressive or Self Injurious Behaviors?** **Please Describe if Yes**

Responsible Party

Name (First, Last)	Age	DOB	Sex	Relationship to Patient	
Mailing Address (put "same" if same as above)		City		State	Zip Code
Employer		Home Phone		Cell Phone	
Social Security #		Expectations for ABA Therapy			
Emergency Contact Name and Phone		Email Address			

Referring Provider

Name (Last, First)	Phone	Fax

Primary Insurance Information

Primary Insurance Compar	Policy Holder name		DOB	Policy #
Insurance Address	City	State	Zip	Group #
Phone Number	Co-Insurance %		Co-pay	Deductible

Secondary Insurance Information

Secondary Insurance Com	Policy Holder Name		DOB	Policy #
Insurance Address	City	State	Zip	Group #
Phone Number	Co-Insurance %		Co-pay	Deductible

Patient Release & Acknowledgement (initial on each line)

_____I verify that the information that I have provided is correct.

_____I authorize the release of medical information necessary to receive benefit information, treatment authorization and process insurance claims to insurance companies and their agencies.

_____I have attached a diagnosis report from my child's medical doctor

_____I have completed all portions of this application

Signature of Insured or Authorized Person	Date

OFFICE USE ONLY COPAY:_____ COINS:_____ DEDUCTIBLE:_____

HOURLY DIRECT PARA:_____ MAX PER YEAR:_____ MAX OOP:_____

HOURLY DIRECT BCBA:_____ HOURLY SUPERVISION/PAPER:_____