APPLIED BEHAVIOR CENTER for Autism

Exceptional Therapy for Exceptional Children

113 West Chapman Road Oviedo, FL 32765
1450 Daniels Road Winter Garden, FL 32787
270 Rangeline Road Longwood, FL 32750

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www.appliedbehaviorcenter.com

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 LONGWOOD LOCATION**
- ☐ **HOURLY THERAPY IN HOME ,SCHOOL OR DAYCARE**
- ☐ **HOURLY THERAPY IN CENTER LONGWOOD**

SUMMER SESSION (CIRCLE LOCATION) OVIEDO WINTER GARDEN LONGWOOD

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)_____

Client Info

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 Comp	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 RATE RBT:_____ HOURS:_____ MAX BENEFIT PER YEAR:_____ MAX OOP:_____

HOURLY RATE BCBA:_____ HOURS:_____ HOURLY RATE SUPERVISION/PAPER:____ /_____ HOURS: _____/_____