APPLIED BEHAVIOR CENTER for Autism

Exceptional Therapy for Exceptional Children

Application for hourly ABA therapy

Incomplete or illegible applications and /or applications submitted without an attached diagnosis report will not be processed. For consideration, please submit application to abc4autism@gmail.com or fax to 321.248.0717

How did you hear about us?

Doctor referral (name) _____Brochure (location)_____
Facebook_____Internet_____Friend_____
Insurance referral_____Bright Feats Catalogue_____CARD_____Flyer_____
McKay website_____Event_____Other(specify)_____

Placement options (please select all that apply)

____HOURLY THERAPY IN HOME
____HOURLY THERAPY AT CHILDS SCHOOL
____HOURLY THERAPY ON SITE AT OUR LONGWOOD LOCATION

Client information

Name (last):_____ First: _____ Age:_____DOB:_____ Sex:_____
Mailing address: _____ City:_____ State:_____Zipcode:_____
Primary diagnosis:_____ Date diagnosed:_____Diagnosing physician:_____Age at diagnosis:_____
Secondary diagnosis:_____ Date diagnosed:_____Diagnosing physician:_____Age at diagnosis:_____
Social security number:_____-____-_____
Current school attending:_____ School county:_____
Funding source(s) for therapy (pick all that apply/ attach documentation):
_____Gardiner(step-up) / Annual funding amount_____ ID#_____
_____VPK/SIS
_____Health insurance
_____Private pay
_____Other
Peanut allergy: _____ (yes or no) Does child have an epi-pen?_____ (yes or no)
Other allergies:_____, _____, _____, _____, _____
Current medications: _____, _____, _____, _____
Current / preivous therapies tried: _____, _____, _____, _____
How does child communicate? (check all that apply): _____PECS _____pointing _____gesturing
_____nonverbal _____sign language _____other
Toilet trained (check one):_____yes, fully _____ yes, partially(explain) _____
_____not toilet trained
Does child exhibit any behavior that would be considered dangerous to himself or others?
_____self-injury (explain)_____
_____aggression (explain) _____
_____ other (explain) _____

Responsible party

Primary : Name (last):_____ First: _____ Age:_____DOB:_____ Sex:_____
Relationship to client:_____ Social security number:_____-____-_____
Home phone: _____ Cell phone:_____ Emai:_____

Secondary: Name (last):_____ First: _____ Age:_____DOB:_____ Sex:_____
Relationship to client:_____ Social security number:_____-____-_____
Home phone: _____ Cell phone:_____Emai:_____

Emergency contact:

Name (last):_____ First: _____ Relationship to client:_____

Expectations for ABA therapy: _____

Referring provider:_____

Primary insurance information

Insurance company: _____ Policy holder name: _____ DOB:_____
Policy#: _____ Group #: _____ Phone number for providers: _____
Address: _____ City: _____ State: _____ Zip: _____

Secondary insurance information

Insurance company: _____ Policy holder name: _____ DOB:_____
Policy#: _____ Group #: _____ Phone number for providers: _____
Address: _____ City: _____ State: _____ Zip: _____

Patient release & acknowledgement (initial on each line)

_____ I verify that the information I have provided is correct to the best of my knowledge
_____ I authorize the release of medical information necessary to receive benefit information, treatment authorization and in order for ABC to process claims through insurance companies and their agencies.
_____ I have attached a diagnosis report from my childs medical doctor
_____ I have completed all portions of this document and understand that incomplete or illegible applications will not be processed

_____	_____	_____
Signature of insured or authorized person	Printed name of insured or authorized person	Date

OFFICE USE ONLY
COPAY: _____COINS: _____ DEDUCTIBLE:_____DED. START DATE: _____MAX OOP:_____ ANN.MAX:_____
Policy#: _____ Group #: _____ Phone number for providers: _____
RBT RATE:_____ BCABA RATE:_____ BCBA RATE :_____ SUPERVISON RATE: _____ PAPERWORK RATE: _____

PROGRAM DIRECTOR ONLY
LOCATION:_____
HOURS APPROVED AND CODES :
_____ _____ _____

_____ _____ _____