Mid-Step Services, Inc.
**Pier Center for Autism**
709 Iowa Street
Sioux City, IA 51105
Ph: 712.522.2961/712.274.2252
www.piercenter.org

Dear Perspective Client,

Thank you for your interest in The Pier Center for Autism. Please complete the Client Registration Form so we have sufficient information to assess how we can be of service. With this document we will assess an appropriate path towards beginning individual services.

Once you have completed the documents, you can mail 1) your intake packet, 2) a copy of your insurance card(s), and 3) your diagnostic reports to the above address. We are available for phone consultation should you have any questions for us.

Thank you again for your interest in our services, and we look forward to working with you.

Sincerely,

Sean P. Peterson, Ph.D., BCBA
Clinical Director
The Pier Center for Autism

# Client Registration Form

Today's Date ___/___/____

Please complete the following information and return to the center along with your insurance information and proof of diagnosis. Once we have received all requested information you will be contacted to set up an evaluation.

## Child Information

Child's Name _____ DOB ___/___/____ Age: _____ Sex: M F

Address _____ City/State/Zip _____

Primary Diagnosis _____ Age of Diagnosis? _____

Physician who gave diagnosis _____ Do you have testing results/report from this physician YES NO

Secondary Diagnosis _____ Age of Diagnosis? _____

## Family Information

Mother's Name _____ Father's Name _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone_____

Email _____ Email_____

Siblings (list names and ages) _____

## Medical Information

Is your child on medication? YES NO

If yes, please explain what and the reason for the medication _____

Are there any medical conditions that we need to consider when delivering therapy? YES NO

If yes, please explain _____

Does your child have any allergies? YES NO Allergies: _____

Is your child on a special diet? YES NO If yes, please describe: _____

_____

## Speech and Language Development

Does your child babble? YES NO Age of first words? _____

Speech and language problem first noticed at what age? _____

How does your child most often communicate? VERBAL SIGN PECS AUGMENTATIVE DEVICE

How much of your child's speech is understood by other adults? _____

Is your child currently receiving speech therapy? YES NO If yes, where? _____

## Basic Developmental Information

At what age did the child sit alone? _____ crawl? _____ walk unassisted? _____ become potty trained? _____

Are there any feeding issues? YES NO If yes, please explain _____

Does your child dress self completely, partially, or not at all? _____

Which hand does child use to eat? _____ to draw or write? _____ to throw a ball? _____

## Therapies and Services

Please check other services that the child is *currently* receiving. Please enclose a copy of the child's most recent IEP, and/or a copy of a recent ABLLS or VB-MAPP assessment if available.

☐ Early Intervention Services ☐ Speech and/or Language Therapy ☐ Occupational and/or Physical Therapy

☐ Vision Services ☐ Hearing Services ☐ Music Therapy

☐ ABA/Verbal Behavior Therapy ☐ Aide/Paraprofessional assistance in school ☐ Feeding Therapy

☐ Other (list) _____

## General Information

Please list things that the child seems to prefer. Consider people, toys, activities or behaviors that s/he engages in or with on a frequent basis.

Preferred persons _____

Leisure Activities _____

Games or toys _____

Videos, music _____

Food, Snacks _____

Drinks _____

Favorite/Frequently Visited stores _____

Events _____

If left alone for a period of time, what will the child do? _____

Please check any of the following behaviors that your child frequently exhibits

___ screaming/tantrums ___ throwing/breaking objects ___ self-injury

___ aggression toward others ___ self-stimulation/stereotypy ___ inattention

___ hyperactivity ___ non-compliance ___ crying

Please describe any behavioral problems, including what you think precedes the behavior and how you respond

_____

_____

## Goals

What are your immediate goals for your child? _____

_____

_____

What are your long term goals for your child? _____

_____

_____

The child who benefits most from an ABA program is a child whose parents are supportive of its methods and participate in its success by transferring techniques to the home environment. Are you willing to work at home with your child? YES NO

Are you able to attend parent meetings to discuss your child's progress? YES NO

Please tell us anything else that you would like us to know about your child _____

_____

_____

_____

The undersigned hereby acknowledges that the information contained in this application is accurate in all respects

_____ _____

Parent/Guardian Signature Date

The Pier Center for Autism
Connecting the Spans of Life
A Mid-Step Services Program

# CLIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: ____/____/____ Sex: M/F

Full Address: _____

Home Phone: (___)_____-_____Email Address (optional): _____

Funding: Please select funding sources you currently have: _____Private Pay ____ Medicaid

_____ Private Insurance ____ Other (Please Specify)

**FINANCIALLY RESPONSIBLE PERSON**

Name: _____ Date of Birth: _____/_____/_____

Full Address: _____

Home Phone: (___)_____-_____ Cell Phone: (___)_____-_____

Employer Name: _____Employer Phone Number: (___)_____-_____

Employer Address: _____

**PRIMARY INSURANCE INFORMATION** *(Please include a copy of the front and back of your card)*

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M/F Insured SS# _____

**SECONDARY INSURANCE INFORMATION** *(Please include a copy of the front and back of your card)*

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M/F Insured SS# _____

I authorize the release of any medical information, by The Pier Center for Autism or its agents, in order to process medical claims with my insurance company. I authorize a copy of this authorization to be used in place of the original and request payment of benefits either to myself or to the above provider who acquires assignment. I acknowledge that I am financially responsible for payment, including any unpaid deductible, co-pay or co-insurance balances, or amounts not covered by my insurance policy.

Signature: _____ Date: _____

The Pier Center for Autism
Connecting the Spans of Life
A Mid-Step Services Program

# AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

I, _____, Hereby authorize **The Pier Center for Autism** and the person/organization listed below to release and exchange psychological, educational, medical, and other information about:

Client's name: _____

DOB: _____

Person/organization receiving/communicating information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

I understand that this authorization is valid for the period of time in which my child is an active client with The Pier Center for Autism. I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

_____ _____
Signature Date

_____ _____
Signature of The Pier Center for Autism staff Date

Relationship to client: ☐ Self ☐ Parent ☐ Guardian