

Dear Prospective 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 them, together with a copy of your insurance card(s), front and back, to the above address. Please also include copies of any relevant medical records, such as diagnosis paperwork. You can also scan and email all documents to our Operations Director, Jeremiah Gray, at jgray@midstepservices.com. Please feel free to call us if you have any questions.

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

Sincerely,

The Pier Center for Autism

Client Registration Form

Today’s Date / / \_

Please complete the following information and return to the Pier Center along with copies of your insurance information (front and back of cards) and proof of diagnosis.

Child Information

Child’s Name DOB / / Age: Sex: M F

Address City/State/Zip

Primary Diagnosis Date of Diagnosis

Name of the Physician and Clinic who gave diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have testing results/report from this physician YES NO

Secondary Diagnosis Date of Diagnosis

Social History/Family History of Mental Health or intellectual/developmental disability(IDD)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 living at the same address (list names and ages) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Anyone else living at the same address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Dosage | Frequency | Time of Day | Reason |
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|  |  |  |  |  |
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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 and list the number of hours per week. **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- Hours/week ­­­­­\_\_\_\_\_\_ [ ]  Speech and/or Language Therapy- Hours/week \_\_\_\_\_\_

[ ]  Occupational and/or Physical Therapy- Hours/week \_\_\_\_\_ [ ]  ABA/Verbal Behavior Therapy- Hours/week \_\_\_\_\_\_

[ ]  Feeding Therapy- Hours/Week \_\_\_\_\_

[ ]  Other (list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behaviors

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 top three treatment goals for your child?

(1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(2)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Schooling

Describe your child’s school situation (which school, last grade completed, curriculum)

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



CLIENT REGISTRATION FORM

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

Full Address:

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#

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