**Stable Life Concepts**

**Client Intake Packet**

(This Page Administration Use Only)

**Observation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return by Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **√** | **Check all that are included in this packet** | | |
| **√** | Client Intake Packet |  | Counseling Addendum |
|  | ABA Addendum |  |  |
|  | Speech Addendum |  |  |
|  | OT Addendum |  |  |
|  |  |  | Other: |
|  |  |  | Other: |

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**Welcome to Stable Life Concepts**

Thank you for your interest in Stable Life Concepts services. We hope that you will find all information helpful and are excited to be a part of your journey. Our primary focus is to provide your child and your family with quality services that are collaborative, innovative and all-encompassing. Integrity, safety, and accountability are of the utmost importance.

Please review all information attached concerning Stable Life Concepts policies and procedures, processes, and services. Fill out all of the attached patient history and background information before the scheduled assessment in order to expedite the process. All information will be used to create an appropriate treatment plan that will allow for success now and in the future.

If at any point you need assistance, please do not hesitate to contact us via phone call, text, or email. We look forward to working with you and your child.

Stable Life Concepts Staff

**Service Agreement and Consent Form**

This document contains important information about our professional services and business policies. It also contains summary information about the Health Information and Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPPA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with the information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligation imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

## **Services Offered**

We will provide services specifically designed to help you and/or your minor child, or otherwise provide you with referrals to other professionals. Our behavioral services consist primarily of individual behavioral and skill assessments and short and long-term ABA service provision to youth in the autism spectrum but are not limited to those areas. Our habilitation experts consist of speech-language pathologists, occupational therapists, counselors, and more.

## **Appointments**

Except for rare emergencies, we will see your child at the time scheduled. We understand that circumstances (such as illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you give us as much notice as possible. This will allow us to offer your time to another person. Fees will be assessed, as outlined below, for instances of No Call No Show as well as attending sessions more than eight minutes past the intended start time. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges. A minimum of 85% attendance of scheduled sessions is required to maintain services. If attendance falls below 85% averaged over three consecutive months, the following actions may take place:

1. A minimum of 85% attendance of scheduled sessions is required to maintain services. If attendance falls below 85% averaged over three consecutive months, clients will cease services and be moved to the waitlist.
2. Parents will receive written notice of the insufficient attendance and a parent meeting will be scheduled at the end of the first month in which attendance has fallen below the expectation.

Initial

## **Confidentiality, Records, and Release of Information**

All services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions as mandated by Texas and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

## **To Protect Client from Harm**

If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, an intended victim, a minor’s parents, or others who could provide protection, or seek appropriate hospitalization.

## **Professional Consultations**

Behavior Analysts, Occupational Therapists, Counselors, and Speech Therapists routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them.

## **Records**

We will review all testing results during our feedback session and offer you opportunities to ask questions and discuss the results with us. You will receive a written report that summarizes the findings. This report will include a summary and interpretation of all individual testing, as well as impressions from individual observations and consultations conducted as a part of a comprehensive individual evaluation. Upon your request, we are happy to provide you with a written summary of our impressions from other meetings, consultations, or observations as well.

## **Payment for Services**

If necessary, we may seek assistance from an outside party in order to collect payment for services rendered to you. In such cases, any disclosures are limited to the minimum that is necessary to achieve the purpose. Copays are the responsibility of the beneficiary.

## **Health Care Insurance**

If we do not file your insurance claims at this time, we will provide you with statements that you may submit to your insurance carrier or complete any forms as required by your insurance carrier in order to obtain reimbursement for out-of-network providers. In order to assist you with obtaining reimbursement for our services, your insurance carrier may require that we provide a clinical diagnosis, or additional clinical information such as treatment plans or summaries, copies of your child’s entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you and your child that is necessary for the purpose requested. By signing this Agreement, you agree that we can provide requested information to your carrier if/when you choose to file a claim for any services that we have provided to you or your child.

## **Professional Records**

You should be aware that, pursuant to HIPPA, we keep clients’ Protected Health Information in two sets of professional records. One set contains the Clinical Record and the other the professional’s personal notes.

## **Client Rights**

HIPPA provides you with several rights with regards to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your records; requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about your policies and procedures recorded in your records; and the right to a paper copy of the Agreement; the attached Notice Form, and our privacy policies and procedures.

## **Contacting Us**

Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends). If you are difficult to reach, please leave sometimes when you will be available.

## **Consent**

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPPA notice from described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

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

Client/Child’s Name Date

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

Parent/Guardian #1 Name Parent/Guardian #2 Name

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

Parent/Guardian #1 Signature Parent/Guardian #2 Signature

**Financial Information**

Stable Life Concepts is willing to participate with any major insurance provider in the State of Texas. We are currently working on Network Credentialing with the following providers: BCBS, United, Aetna, and Cigna. Please contact us to find out if we are currently providers for your insurance company.

We also take self-pay. We accept payment via check or credit cards (Visa, MasterCard or Discover).

All fees are based on the service performed including copays.

**What is Stable Life Concepts?**

Stable Life Concepts is a non-pharmaceutical treatment facility for behavior-based disorders; providers primarily treat Autism Spectrum Disorder (ASD). Stable Life Concepts is not a daycare and all clients must have a current ASD diagnosis for ABA therapy, or appropriate diagnosis for habilitation services. ABA therapy is a long-term treatment program, and while some goals will be met quickly, others may take a considerable amount of time. Treatment can take a **considerable buy-in by guardian/parent** as well as treatment providers and studies have shown **greater treatment efficacy** **when** **guardian/parents align their home practices with clinic practices**.

**Types of Services Stable Life Concepts Provides**

\* Types of services offered may vary by location

## **Center-based 1:1 Therapy**

Stable Life Concepts provides a center-based program in which basic skills are taught to each child to enhance learning. Each child participates in a 1:1 session with a BCBA, BCaBA, or Registered Behavior Technician, based upon his or her individual programming created by the BCBA. Stable Life Concepts also offers 1:1 session with a SLP, OT, or Counselor.

Community-based or School-based 1:1 Therapy

Once prerequisite skills are mastered in the center-based environment, these skills will be utilized and tested for generalization in the community and school environments (when permitted).

**Functional Behavior Assessment (FBA)**

This is designed for children who may have behaviors that are interfering with their ability to learn. An analysis of the behavior of concern will be completed via parent interview and direct observation. Once the analysis is conducted, a plan will be written to address the behaviors of concern.

**ABA Parent Training**

All ABA services include a component of parent training. In order for center-based ABA therapy to have lasting effects, parents must assist the child with bringing the skills he or she learns at the center to other natural environments, especially in the home and community settings. Parent education and trainings will be available through Stable Life Concepts. Participation by parents, guardians, or caretakers is not only encouraged but expected for any program to be successful.

**Treatment Approach**

**Treatment Teams**

Stable Life Concepts providers hail from diverse backgrounds and together create strong treatment dynamics. We provide therapy from a **“treatment team”** approach. The team approach allows multiple providers to evaluate and make recommendations to the treating providers to help ensure no stone is left unturned. The team approach also helps with skill acquisition and generalization.

1. I/We understand that Stable Life Concepts takes a collaborative approach to treatment. Treatment teams are utilized in order to provide the most **comprehensive treatment** possible. A treatment team consists of a BCBA, and multiple Behavior Therapists, with the possibility of Speech Language Pathologist, Occupational Therapist, and in some cases a outside providers. Each client will be assigned to a treatment team and each team has their own treatment dynamic.
2. I/We understand that Stable Life Concepts provides a **long-term intensive program**. Goals and needs **may change** over the course of treatment. Clients are continually evaluated and may be assigned to **other teams** to better meet their treatment needs and/or help with skill acquisition and generalization.
3. I/We understand that the nature of ABA treatment is to **change behaviors for the positive** and this **WILL NOT happen overnight**. While treatment will occur daily, treatment efficacy (outcomes) should be viewed over longer periods of time.
4. I/We understand that I/we will play important roles in treatment outcomes. In order to facilitate skill acquisition and generalization outside of the clinic, I/we will **actively work on goals** and communicate progress in the home, school, and community. This may, at times, include simple data collection.
5. In order to help generalize skills and behaviors, I/we are willing to attend a **minimum of ONE individual** and **ONE group** parent training **per month** with a goal of bi-weekly individual trainings and one monthly group training.

Initial

**Rules and Regulations**

## **Scheduling and Sessions**

1. We offer **2-hour and 3-hour** sessions (part-time) and **6-hour** sessions (full-time) for ABA. The parent or legal guardian should arrive no later than 10 minutes prior to the end of the session for consultation with the therapist.
2. We offer 30 minute Speech sessions, 1 hour Occupational Therapy sessions, and 50 minute Counseling sessions. Any variations to be determined by Licensed Specialist. The parent or legal guardian should arrive no later than 10 minutes prior to the end of the session for consultation with the therapist.
3. Please provide **30 days written notice** on significant changes to scheduling in order to facilitate consistency in service delivery. This may include a request for change in schedule, long vacation, or termination of services.
4. Sessions will involve direct services with the client, time to prep materials, data collection, and time to discuss the session with the parent.

Initial

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## **Absences, Vacations and Holidays**

1. I/We understand that in the event of inclement weather, all programs at Stable Life Concepts may follow the local public school’s procedures. I/We further understand that the Clinical Director has the discretion to cancel appointments due to exigent circumstances if needed, even if the schools have not closed.
2. SLC has scheduled vacation and holidays where all services will be canceled. I/We understand that we will be provided with a calendar of those scheduled days in advance.
3. I/We understand that requests for leaves of absence or extended vacation from the program must be submitted with **at least 30 days’** notice and will be reviewed by the Clinical Director. Upon approval, arrangements will be made on a case by case basis.
4. I/We understand that if my child is absent from the clinic for 15 consecutive days, they may be placed on the waiting list.

Initial

**Cancellation Policy and Fees**

**No Call No Show**

1. A fee will be assessed on the third No Call No Show that happens within a calendar year. The fee will be $25.00 billed directly to the family. A fee will be assessed for EVERY No Call No Show after the initial three within a calendar year. A No Call No Show is defined as Any time a client or parent/guardian fails to cancel a session prior to 15 minutes within the session starting.
2. A parent training will be scheduled for the 3rd No Call No Show to discuss potential schedule changes, barriers to attendance, as well as clinical impact.

**Tardiness:**

1. A fee of $15.00 will be assessed on the third tardy within a calendar year. A fee will be assessed for EVERY tardy after the initial three within a calendar year. This fee will only be assessed if there was not at least 24 hours notice given. A tardy is defined as attending a session more than 8 minutes after the intended start time.
2. Three tardies in a quarter, regardless of notice given, will require a parent training to discuss potential schedule changes, barriers to attendance as well as clinical impact.

Initial

## **Illness Policy**

1. I/We understand that if my child’s temperature is at or above **100 degrees** I/we will be contacted and that my/our child will be required to be picked up.
2. I/We understand that my child must be **fever free for a minimum of 24 hours** before returning to therapy, without the aid of any fever reducing substance.
3. I/We understand the I/we will be called to pick up my child from therapy if he/she has **two (2) or more** unexpected instances of **diarrhea**. I/We understand that my/our child will not be permitted to resume therapy **until 24 hours** with **NO diarrhea** instances.
4. I/We understand that I/we will be called to pick up my child from therapy if he/she has **one (1) or more** instances of vomiting. I/We understand that my/our child will not be allowed to resume therapy **until 24 hours** have passed with **NO vomiting**.
5. I/We understand that I/we **MAY BRING** my/our child to therapy if he/she has a **seasonal allergies** (slight occasional cough, clear runny nose, occasional sneezing). I/we further understand I/we **MAY NOT BRING** my/our child if my/our child has discharge of any other color than clear.
6. I/We understand that if my/our child has **any rash other than a mild diaper rash** I/we must bring a **note from the doctor** stating the rash is not contagious.
7. I/We understand that by law my/our child **IS NOT** permitted to be seen for therapy if he/she has contracted a communicable disease. Examples of communicable diseases are (but not limited to): Conjunctivitis (Pink eye), Impetigo, Hepatitis A, Scabies, Ringworm, Infections, Diarrhea, Chicken Pox, Scarlet Fever, Lice, and Strep Throat. I/we understand that if my/our child is thought to have a communicable disease I/we will be contacted and that my/our child will not be permitted to be seen for therapy. I/we further understand that my/our child will not be permitted to attend therapy until a doctor’s note has been provided stating that my/our child is no longer contagious.

Initial

**Medical Information**

1. I/We understand that I/we have agreed to release my/our child’s medical and psychological records to Stable Life Concepts. Releasing these records will allow us Stable to review my/our child’s diagnosis, developmental, medical, levels of intellectual, behavioral, and social functioning as well as their medical history.
2. I/ We understand that I/we give Stable Life Concepts permission to seek medical assistance for my/our child in case of an emergency. Medical attention will be sought without my/our verbal permission if I/we are either unreachable, time is of the essence, or other unforeseeable circumstances arise.
3. I/We understand that there are medical conditions, as well as certain medications (such as insulin), that the staff of SLC is not qualified to deal with and/or administer. If a medical condition arises that the staff is NOT able to handle, my child may not be able to be seen by the staff.

Initial

# **Lapse in Authorization**

1. I/We understand that **if an authorization is removed** or missing, my/our **child will not be eligible** for treatment **until the authorization is reinstated**.
2. I/We further understand the importance of timely submission of paperwork in order to keep the authorization active. If **an authorization is delayed or removed** due to lack action on my/our part, I/We understand that my/our **child may be put back on the waitlist**.

Initial

# **Observation of Client**

1. I/We understand that my/our child could be videotaped while receiving therapy from SLC for the purpose of training staff members and/or receiving video updates on my/our child’s progress. I/We understand that any video will be kept confidential.
2. I/We understand that professionals, other clients, potential clients, staff, and therapists in training will occasionally be observing therapy. In these cases, I/we will be informed of the purpose of the observation.
3. I/We understand that I/ We may view my/our child while he/she is receiving therapy. In addition, I/we may be asked to observe procedures in order to promote generalization.

Initial

**Photography and Video**

It is beneficial to use photographs and videos of the clients within the therapeutic setting. It can also be helpful to use client photographs and videos in presentations, educational materials, and trainings.

Please indicate below your consent for SLC to take and use pictures and/or videos of your child for these purposes. **Declining consent will not affect your access to therapy in any way**.

**Please Circle One:** 1. Center Use Only 2. Center and Public Use. 3. Declined Consent

Initial

**Technology and Personal Items**

Technology (i.e. iPad, tablet, phones, handheld games) can be used as a reinforcer or as an augmentative communication system. It is the parent’s responsibility to label the device and provide any charging devices. SLC will not be responsible for any loss or damage to any device or any personal items brought to the clinic.

Initial

**Signature Agreement for Rules and Regulations of Stable Life Concepts:**

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

Signature (Parent/ Guardian #1) Date

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

Signature (Parent/ Guardian #2) Date

**Release, Indemnification, and Hold Harmless Agreement for Transportation**

As a necessary and indispensable part of my being allowed to participate in community outings, field trips, and other necessary transportation sponsored by Stable Life Concepts, I do hereby agree and represent, on my behalf and on behalf of my heirs, personal and legal representatives, successors, assigns, employees, dependents, and associates as follows:

I , \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ willingly assume any and all risks and danger inherent with or incidental to myself and my minor child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ participation in all sessions and travel to and from community locations, or classes, and any and all activities in connection with any such activities sponsored by Stable Life Concepts.

I understand and accept that accidents occur, although Stable Life Concepts will make every attempt to maintain the utmost safety for all parties involved. In any event and regardless of the nature of any injury, damage, or loss that I may suffer or that may accrue to the benefit of or damage to any of the persons named above, no claim or demand will be made on or against you, Stable Life Concepts, or on or against any of the agents, representatives, associates, employees, or contractors of Stable Life Concepts.

I give permission for my child to be transported to and from the below activities by staff or contractors of Stable Life Concepts:

|  |  |  |  |
| --- | --- | --- | --- |
| **√** | **Check all that apply** | | |
|  | Community Outings |  | Other: |
|  | Medical (Clinics/ER/Hospital) |  |  |
|  | Field Trips |  |  |

This agreement is knowingly, willingly and freely given, and I fully understand and agree that it is a release and waiver of certain rights I may have and shall act as a complete bar against any claims that might otherwise be brought.

I have been given a copy of this agreement, which I have read, and I understand and acknowledge its terms. Its contents have also been explained to me. I understand the consequences of my signature to this agreement.

Signature of Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sunscreen Application Waiver**

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| --- | --- | --- |
| **Sunscreen Application Waiver** | | |
| As the parent or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I recognize that too much sunlight may increase my child’s risk of getting skin cancer or other skin disorders in the future. Therefore, I give my permission for personnel at Stable Life Concepts to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when he or she will be playing outside. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs. | | |
| **Please check all of the following that apply:** | | |
|  | I do not know of any allergies my child may have to sunscreen. | |
|  | Staff may use the sunscreen of their choice following the directions and recommendations printed on the bottle. | |
|  | Please DO NOT apply sunscreen to the following areas of my child’s body: | |
|  | My child is allergic to some sunscreen, please ONLY USE the following brands: | |
|  | I have provided the following sunscreen for use on my child: | |
| Parent/Guardian Print: | | Date: |
| Parent/Guardian Sign: | |

**Client Intake Questionnaire**

The following questionnaire is to be completed by the child’s parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding your child. Stable Life Concepts will hold information provided by you as strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law.

(PLEASE PRINT CLEARLY)

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Demographics** | | | |
| Client Name (Last, First, Middle): | | | |
| DOB: | Age: | Sex: | Gender: |
| Address: | | | |
| Phone 1: | | | Type: |
| Phone 2: | | | Type: |

|  |  |  |
| --- | --- | --- |
| Insurance: | | |
| Sponsor ID/Member/Policy Number: | | |
| Sponsor Name: | | DOB: |
| Address: | | |
| Phone: | Email: | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| School District: | | | | Name of School: | | | | |
| Grade: | Date Enrolled: | | | Date of IEP: | | | | |
| Placement: | Mainstream: | | Inclusion: | | Resource: | | Other: | |
| Days of Attendance (circle all that apply): | | | MON | TUE | WED | THU | FRI |  |
| Times of Attendance (indicate time below day): | | |  |  |  |  |  |
| Teacher(s): | | | | | | | | |
| Did teacher(s) report any problems? (please explain): | | | | | | | | |
| **If client has been in Special Education, please check any of the following they may have had:** | | | | | | | | |
| * 504 Plan | * IEP | | * Psychological Evaluation | | | * Behavior Intervention Plan | | |
| * Occupational Therapy Evaluation | | * Physical Therapy Evaluation | | | * Adaptive Technology Evaluation | | | |
| * Speech Therapy Evaluation | | * Other: | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family Demographics** | | | | |
| Mother’s/Guardian’s Name (Last, First, Middle): | | | | |
| Address (if different from above): | | | | |
| Phone 1: | | | Type: | |
| Phone 2: | | | Type: | |
| Email: | | | Occupation: | |
| Father’s/Guardian’s Name (Last, First, Middle): | | | | |
| Address (if different from above): | | | | |
| Phone 1: | | | Type: | |
| Phone 2: | | | Type: | |
| Email: | | | Occupation: | |
| Marital Status of Parents (please check one): | * Married | * Separated | * Divorced | * Single |
| Parent(s)/Guardian with custody of child: | | | | |
| Step-parents: | | | | |
| Was child Adopted? | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Siblings Names** | **Age** | **Relationship** | **Living at Home** | **School** | **Grade** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Others Living in Home** | **Age** | **Relationship** | **Years Living in Home** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Client Confidentiality Contact Form**

Client confidentiality is a top priority for Stable Life Concepts. Therefore, it is important that you provide us with the

following information to ensure there is no violation of your privacy.

In the event that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am unable to be reached, Stable Life Concepts

may leave information with the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **√** | **Check all that apply** | **Name** | | **Number** |
|  | Call another adult in household | **1** |  |  |
| **2** |  |  |
|  | Call another cell phone | **1** |  |  |
| **2** |  |  |
|  | Leave message on another voicemail | **1** |  |  |
| **2** |  |  |
|  | Call my work | **1** |  |  |
| **2** |  |  |
|  | Leave message on work voicemail | **1** |  |  |
| **2** |  |  |
|  | Text my cell phone | **1** |  |  |
| **2** |  |  |
|  | Other: | **1** |  |  |
| **2** |  |  |

OPT OUT (Initials) \_\_\_\_\_\_\_\_\_\_\_\_. In the event that I am unable to be reached, Stable Life Concepts MAY NOT leave information with anyone but myself. I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of Stable Life Concepts.

Parent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Record Release Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Request/authorization to release confidential medical and mental health records and information** | | | | |
| **SOURCE OF INFORMATION** | | | | |
| Facility | | | Phone: | |
| POC: | | | Email: | |
| Address: | | | | |
| **IDENTIFYING INFORMATION** | | | | |
| Client Name (Last, First, Middle): | | | | |
| Address: | | | | |
| Phone: | | DOB: | | SS# |
| Parent/Guardian (Last, First, Middle): | | | | |
| Address: | | | | |
| Phone: | | | | |
| **I hereby authorize the source named above to send the records marked below to Stable Life Concepts at the address above (check all that apply):** | | | | |
|  | Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness: | | | |
|  | Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by staff member or client. | | | |
|  | Psychiatric evaluations, reports, or treatment notes | | | |
|  | Treatment plans, recovery plans, aftercare plans | | | |
|  | Admission and discharge summaries | | | |
|  | Social histories, assessments with diagnosis, prognoses, recommendations, and all similar documents | | | |
|  | Information about how the client’s condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work. | | | |
|  | Workshop reports and other vocational evaluations and reports. | | | |
|  | Billing records | | | |
|  | Academic or educational reports | | | |
|  | Report of teachers/staff observations | | | |
|  | Achievement and other test results | | | |
|  | Other: | | | |

I further authorize the source named above to speak by telephone with staff of Stable Life Concepts about the reasons for my/the client’s referral, and the relevant history or diagnosis, and other similar information that can assist with my/the client’s receiving treatment or being evaluated.

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

Client Signature Printed Name Date

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

Signature of parent/guardian Printed Name Date

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| **Past Medical history** | | |
| Birth History | | How was pregnancy and delivery?  natural birth (vaginal delivery)  C-Section (planned)  emergency C-Section  How many weeks old was your child when he/she was born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Birth weight/height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Jaundice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NICU? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Receive oxygen? ­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Receive ventilator? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Receive feeding tube? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please provide any additional details:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Developmental Milestones | When did your child do the following?  Started Babbling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  First Word: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Stand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Walk: ­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Eat Purees (baby foods): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Eat Table Foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Use a Spoon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Use a Fork: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Use a Knife: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Gained Bladder Control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Gained Bowel Control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Known Past Conditions (please check any client has had):** | | | |
| * Earaches | * Hives | * Broken Bones | * Ear Infections |
| * Itchy Eyes | * Constipation | * Eczema | * Seizures |
| * Dehydration | * Heart Problems | * UTI | * Diabetes |
| * Hemorrhoids | * Injuries/Suregery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * Other: |
| * Known Allergies: | | | |

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| **Current Medication(s)** | **Purpose** | **Dosage** | **Dates** |
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| Client’s Physician: | Practice Name: |
| Address: | |
| Phone: | Fax: |

|  |  |
| --- | --- |
| Client’s Physician: | Practice Name: |
| Address: | |
| Phone: | Fax: |

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| --- | --- |
| Client’s Physician: | Practice Name: |
| Address: | |
| Phone: | Fax: |

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| **Other Considerations** | | | |
| Dominant writing hand: | * Right | * Left | * No preference |
| Known vision problems: | * Yes | * No | Date of last vision test:  Who performed: |
| Known Hearing Problems: | * Yes | * No | Date of last hearing test:  Who performed: |

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| **Previous Services/Therapy** |
| Has your child received therapy before?  ECI (Early Child Intervention, 0-3 yrs old): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Occupational Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Speech Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physical Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ABA Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has your child had a hearing and vision screenings done? ­­­­­  Yes, normal  Not yet  Yes, he/she has some difficulties hearing  Yes, he/she has cochlear implants or other hearing aids |

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| Company: | | | Dates of service (start/end): |
| Provider: | | | Phone: |
| Address: | | | |
| May we contact previous provider? | * Yes | * No | How many hours of therapy per week were attended? |

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| --- | --- | --- | --- |
| Company: | | | Dates of service (start/end): |
| Provider: | | | Phone: |
| Address: | | | |
| May we contact previous provider? | * Yes | * No | How many hours of therapy per week were attended? |

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| **Authorization for Emergency Medical Treatment** | | | | |
| Physician’s Name: | | | Medical Facility: | |
| Health Insurance Co: | | | Insured: | |
| Policy #: | | **\*Please attach copy of front and back of insurance card to this form** | | |
| Allergies: Y N | Explain: | | | |
| Other Allergies: | | | | |
| **In the event of an emergency, contact:** | Name: | | Relation: | Phone: |
| Name: | | Relation: | Phone: |
| In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Stable Life Concepts, agents and/or staff to:   1. Secure and retain medical treatment and transportation if needed; and 2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment. | | | | |
| Consent Plan:  This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed “lifesaving” by the physician. This provision will only be invoked if the person(s) above is unable to be reached. | | | | |
| Consent Signature:  (Client, Parent, or Legal Guardian signed in the presence of program personnel) | | | | Date: |
| Program Personnel Initials: | | | | Date: |

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| **Non-Consent Plan** | |
| I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place: | |
| Non-Consent Signature:  (Client, Parent, or Legal Guardian signed in the presence of program personnel) | Date: |
| Program Personnel Initials: | Date: |