STEPPING STONE
KIDS THERAPY

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

Child's Legal Name: _____ Date of Birth: _____

Age: _____ Male: _____ Female: _____ Primary Care/Pediatrician: _____

Legal Guardian: _____ **Legal Guardian**: _____

Can we leave a message: **Yes** **No**

Home Number: _____

Cell Number: _____

Work Number: _____

Best number to reach you on: _____

Email: _____

Physical Address: _____

City, State, Zip: _____

Mailing Address, if different from physical address: _____

City, State, Zip: _____

Child's diagnoses and physician who provided initial diagnosis:_____

Who referred you to our office? _____

Who does the child reside with? _____

If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person: _____

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INSURANCE INFORMATION (Please fill out ALL areas)

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Insured's Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

Please **initial** the following statement:

_____ **I DO NOT HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAN THE ABOVE MENTIONED.**

EMERGENCY MEDICAL RELEASE

In the event medical attention is required for your child while in the premises of Stepping Stone Kids Therapy, we need your authorization to implement treatment. Please read and sign statement below.

As legal guardian of _____, I give my permission for Stepping Stone Kids Therapy to contact emergency personnel in the event of a medical emergency.

_____ _____

Parent/Legal Guardian Signature **Date**

EMERGENCY CONTACT

NAME: _____ **PHONE:** _____

RELATIONSHIP: _____

MEDICATION/ALLERGIES/CONDITIONS
Medications (Include prescription drugs, over the counter meds, vitamins, and homeopathic medications):

_____ _____

_____ _____ _____ _____

Allergies/Reactions:

_____

Diagnoses (Any known medical diagnosis or medical condition, with dates of diagnosis if known):

_____

Does your child require an Epi Pen: **Yes** **No**

I, _____ state that the above is true and complete to the best of my knowledge, I authorize Stepping Stone Kids Therapy to provide food items fitting within the parameters above to my child for behavior reinforcers. If applicable, I authorize Stepping Stone Kids Therapy to administer the Epi Pen that I have provided for my child in the event of an anaphylactic emergency. I understand that by signing this form I am releasing Stepping Stone Kids Therapy of any liability herein.

Parent Signature: _____ Date: _____

PHOTO PERMISSION
Please **initial** the following OPTIONAL statements:

_____ I give permission for photos/videos of my child to be used for the purposes of treatment, education, and documentation.

TECHNOLOGY PERMISSION
Please **initial** the following OPTIONAL statements:

_____ EMAIL: I give permission to Stepping Stone Kids Therapy to correspond with my child's legal guardians and care team via e-mail regarding treatment, documentation, and home programming. I understand that e-mail is encrypted internally; however, once an email is sent externally, correspondence may potentially be intercepted by an outside party.

_____ TEXT: I authorizeStepping Stone Kids Therapy to send text messages to my cell phone related to my child's therapy. I understand that standard data and text messaging rates will apply to any messages received

from. I agree not to hold Stepping Stone Kids Therapy liable for any electronic messaging charges or fees generated by this service. I also understand that I may opt out at any time via text (replying “STOP” at any time) or by alerting the front desk. If my cell phone number changes, I will inform the front desk/Clinic manager.

AUTHORIZATION AND CONSENT FOR EVALUATION, TREATMENT, AND OPERATIONS:
Please **initial** the following statements:

_____ I hereby give Stepping Stone Kids Therapy permission to evaluate and treat my child, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and Stepping Stone Kids Therapy staff.

_____ I understand that state representatives for insurance certification or licensing and quality assurance may review my child’s records. I understand that all practices of confidentiality will be followed in use of the information gathered.

_____ _____
Parent/Legal Guardian Signature **Date**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):
I acknowledged that I have viewed, read, and understand the HIPAA Policy (attached at the end of this packet) and have been informed of my rights as a patient’s parent/guardian.

_____ _____
Parent/Legal Guardian Signature **Date**

List the names of the programs and people that have worked or are working with your child outside of Stepping Stone Kids Therapy

Service	Practice/School Name	Provider Name	Last Seen/Frequency
Pediatrician/Physician			
Child Care Program			
Preschool			
School			
Occupational Therapist			
Speech Therapist			
Physical Therapist			
Counselor/Psychologist			
Infant Learning Program			
Head Start Program			
Caseworker/Care Coordinator			
Dietitian/Nutritionist			
Specialty Doctor			
Other			

I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution, to release all of medical information by any means of communication toStepping Stone Kids Therapy LLC.

_____ _____

Parent/Legal Guardian Signature **Date**

****If your child has an IEP through his/her school, please bring us a copy for our records. ****

****If your child has any additional testing, please bring us a copy for our records. ****

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HISTORY FORM

Please answer the questions to the best of your ability and in as much detail as possible. Please add any information that you feel is important but is not covered on this form.

General History

Child's Name: _____ Nickname? _____ DOB: _____

Current concerns: _____

What are your primary goals for therapy?

_____

Is your child currently receiving any other therapy services? Please list providers, locations, and days/times:

_____

Please explain if any other medical or behavioral health referrals have been made:

_____

Developmental History

Please indicate at what **age** each major milestone was reached:

Sitting up by self: _____ Crawling: _____ Walking: _____

First word: _____ Two words together: _____

What was their first word? _____ What was their first phrase? _____

When did you first become concerned about your child's development?

_____

Please provide detail regarding the concerns of your child's development, if any.

_____

Please provide any problems or interfering behaviors of concern

_____

Please state the expectations/goals that you have for your child while engaging in a behavioral program

_____

Medical History

Please describe illnesses, hospitalizations, or surgeries that your child has had and when they occurred:

_____

Social History & Living Situation

Please describe your child's living situation (and any recent changes):

_____

Siblings' names and ages: _____

If your child was adopted, please answer the following questions:

Age of adoption: _____ Is your child aware of adoption? YES NO

Previous home experiencesprior to adoption: _____

Educational History

Grade: _____ Name of school: _____ Teacher: _____

What kind of classroom (e.g., regular ed, special ed, life skills, hospital homebound, homeschool, etc.):

_____

Does your child have an IEP, 504 Plan, accommodations? YES NO
What services does your child receive at school? _____

Names of any school therapists? _____

Personal Information

Please describe your child's personality:

How does your child handle changes and variation in routine?

What games, activities, and toys does your child enjoy?

Describe how your child interacts with other children:

Describe your child's sleeping habits/patterns:

Describe child's ability to communicate (verbal, sign, nonverbal):

STEPPING STONE
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PATIENT AGREEMENT

Stepping Stone Kids Therapy offers ABA therapy services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your child's therapy needs.

Following the initial assessment visit. We are pleased to serve your ABA needs and encourage your feedback to alert us to anything we can do to provide your child with the highest quality of care.

We require certain information from each patient to begin providing care. The attached forms need to be completed for us to begin serving your child as our patient. Please do your best to complete all the information. If certain information does not apply to your child, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payor has different guidelines for allowing coverage of ABA services. It is helpful if you let us know your healthcare payor when starting service so that we may find out if prior authorizations are needed. If your child is a Medicaid beneficiary, please ask your primary care provider to send us a referral for your initial assessment to fulfill Medicaid requirements. If your healthcare insurance payor does not cover ABA services, you are welcome to make self-pay arrangements for the usual and customary pricing of our services.

PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICE

Private insurance companies may have limits on the amount of ABA covered. Once you have exceeded the financial limit of your benefits and you do not have additional healthcare coverage, you are responsible for the payment of your child's services. Additionally, private healthcare insurance payors have deductible and co-payments for ABA services that are the responsibility of the patient.

While this practice will not discontinue your child's services for financial hardships, it is expected that patients pay at the time of service and/or set up payment arrangements. *Please see attached patient payment policy and credit card authorization form

PRIVATE PAY

Payment is due at the time of service. Once a year your child will receive a reassessment to update current plan and review progress. This requires an additional fee;our clinic manager will schedule date and time for the reassessment and discuss payment and fee associated.

COLLECTION OF PAST DUE ACCOUNTS

We communicate with our patients' parents/guardians to resolve past due accounts in all cases. If we cannot reach a patient's parent/guardian by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your child's caregiver experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either in writing or by phone at (239) 351-3715. A member of our management team will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for Stepping Stone Kids Therapy to provide ABA services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

_____ _____

Parent/Legal Guardian Signature **Date**

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are willing to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our financial policy.

Payment, co-payment, deductibles, and co-insurance for services are due each visit for charges incurred up through your last visit. We accept cash, checks, VISA, MasterCard, and Discover Card. **Please understand that you are financially responsible for all charges, whether they are paid by insurance.**

Please read carefully:

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. As a courtesy to our patients, we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason any portion of a bill is not paid by your insurance within 60 days from the date of service, you agree to make arrangements for prompt payment.

2. Should your insurance coverage change, our office should be notified within 30 days of the effective date and the card or stickers should be available for copying. If you fail to provide us this information, your account and all future balances will be your responsibility. We will no longer bill insurance and you will be responsible for submitting claims to your insurance. Payment will also be due at the time of service in full.

3. Any returned checks will be subject to an NSF fee of $25.00 which will be due at the next visit.

Please **initial** the following statements:

_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, and co-insurance.

_____ I give Stepping Stone Kids Therapy permission to submit bills directly to the insurance carrier.

I hereby understand the above financial policy and agree to abide by it.

_____ _____

Parent/Legal Guardian Signature **Date**

CANCELLATION POLICY

Our clinic strives to provide the best therapy services possible. To ensure optimal use of valuable therapy time, **please discuss schedule changes at the end of your appointment with your therapist and the front desk administrator/clinic manager**. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday morning appointments, our office appreciates being notified no later than Friday noontime. This will allow other patients in need of care to be accommodated as we have many patients. It is both unfair to the other patients and therapists to not allow for others to schedule in the open time slots.

Please review and initial all statements below:

_____ I understand it is my responsibility to communicate with the front staff/clinic manger of any schedule changes or appointment cancellations.

_____ Three consecutive no-shows will require your child to be placed on a hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, your child will lose his/her therapy time and be placed on our information list.

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, (such as for an extended trip), we will hold your therapy spot for up to two weeks. We will then place you on the information list and will fit you back in the schedule as soon as we can.

I hereby understand the above cancellation policy and agree to abide by it.

_____ _____

Parent/Legal Guardian Signature **Date**

STEPPING STONE
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CLINIC ETIQUETTE

Once again, we welcome you to Stepping Stone Kids Therapy. We are honored that you have chosen our clinic to meet the needs of your child and your family. We hope that you are comfortable here and always feel welcome. Please know that you can approach us with any comments or concerns regarding our space and how it is used. To make a comfortable and safe place for all our families and our staff, we ask that families follow our clinic etiquette plan. Please read and become familiar with the following expectations.

1. Before entering treatment areas without a therapist, please check in at the front desk/clinic manager to allow for patient confidentiality and compliance with HIPAA policies.
2. Closely monitor your children's behavior in the waiting room to ensure that they are playing safely and appropriately with other children. Please do not allow children to climb on, jump from, or disassemble the waiting room furniture or toys.
3. Please clean up after your children in the waiting room. Help them replace any books or toys they may have used and throw away any trash that may have accumulated.
4. Accompany all younger children and those needing assistance or supervision to the restroom; this includes using the restroom for hand washing.
5. If you have children in diapers or pull-ups, please bring a diaper bag to therapy and be prepared to change your child if necessary.
6. Do not allow your children to enter the treatment area unaccompanied.
7. For safety reasons, please do not allow your children to play with the doors in the waiting room.
8. We discourage bringing toys from home to treatment sessions unless your therapist requests them or gives permission to bring them. Your therapist will choose toys from our clinic with a specific therapeutic purpose.
9. If you are observing your child's treatment session, remain in the same room as your child and their therapist. To protect the confidentiality of all children in our clinic, we ask that if you need to leave the treatment room for any reason, you return to the waiting room and wait for the session to end. If your child and their therapist leave the room, either follow them or wait for them in the waiting room.
10. Please keep cell phone and tablet use to a minimum in treatment areas and place phones on vibrate or silent. Cell phone and tablet use is acceptable in the waiting room and other common areas, but please keep phone conversations brief and use headphones if watching videos or listening to music. Please take extended phone conversations outside the waiting room.
11. Please be mindful of the content discussed in your conversations (phone or in-person) or viewed on your electronic devices. Please only discuss topics or select websites, videos, music, etc. which are appropriate to discuss/view in the presence of children.
12. Please do not ask therapists about other clients or families at the clinic. To comply with HIPAA, we cannot answer these questions.
13. Be respectful of the 'end of session' time. Please arrive 10-15 minutes prior to end of the therapy session. In most cases, there is another family waiting to begin therapy. If you need additional time to discuss a concern, ask questions, or problem-solve treatment activities, please join your child's session or arrange for an alternative time to discuss those topics with your child's therapist.

As your team, you can expect us to:

1. Begin and end your appointments in a timely manner.
2. Inform you of the goals targeted and the progress made during each session.
3. Provide strategies and ways for you to address goals at home to increase carryover.
4. Provide parent training
5. Assist you in any way we can, from brainstorming ideas to help make your families' lives easier at home to talking with school therapists, etc.
6. Keep anything you share with us confidential.
7. Provide the best therapy we possibly can.

If you have any questions about the above information, please don't hesitate to ask us. We are here to help you!

I have read and understand the above Clinic Etiquette and agree to abide by it.

_____ _____

Parent/Legal Guardian Signature **Date**

STEPPING STONE KIDS THERAPY SCOPE OF PRACTICE

Characteristics of Persons Served:
Children ages 2 to adolescence (less than 16 years of age for new clients and up to 18 years of age for continuing clients) may be served.

Medical Acuity & Medical Stability:
Children must be healthy and cleared for treatment by their physician. Children may not receive services if they have illnesses such as: fever of 100.5 or greater; pink eye; vomiting and/or diarrhea; or other highly contagious viruses and/or diseases.

Admission Criteria:
Children who experience delays, or are at significant risk for delays, in any area of development which negatively affects his/her functional performance and ability to participate in home, community and school activities.

Children from 2 through 16 years of age will be considered for evaluation. Children 16 years and older may be seen on a case by case basis if he/she has lost a skill due to an accident or illness.

- Financial responsibility is established in accordance with the Financial Policy.
- An evaluation is completed which identifies the need for intervention.
- Additional factors considered before admission include areas of expertise of therapy staff and availability of appropriate treatment materials and equipment. If a client would benefit from treatment but is not approved for services due to the factors previously identified, he/she may be referred to other agencies that can provide needed services.

Discharge Criteria:
It is our policy to discharge clients who meet any of the following criteria: are 18 years of age; no longer demonstrate need for intervention; do not appear to benefit from continued services; are not meeting financial responsibilities; do not meet the required attendance; are removed at the request of the caregiver; or are removed at the discretion of the agency (including for safety reasons).

- **No Longer Demonstrates Need**:
  If a child has demonstrated sufficient progress in therapy and testing reveals the child's skills are at age-appropriate levels (i.e., no further intervention is indicated), the therapist will review the child's progress with the parent/caregiver and plan a discharge date.

- **Does Not Appear to Benefit**:
  Progress in therapy is reviewed on a continuous basis. If a client does not meet therapy goals and/or does not demonstrate progress on re-evaluation after six months in therapy, the treating therapist will discuss the lack of progress and the treatment plan with their clinical supervisor and the child's caregiver. They may revise the treatment plan to better fit the child's needs at any time.

  If a client does not meet therapy goals and/or does not demonstrate progress on a re-evaluation during the second six-month treatment period, the treating therapist will discuss the treatment plan with their clinical supervisor and the child's caregiver. An interdisciplinary team review shall be initiated. This discussion will include the possibility of revising the treatment plan, increasing or decreasing the frequency of sessions, and discharge if no progress continues to be noted.
  At the end of 18 months of treatment, if no progress has been noted and the above steps were taken, the client may be discharged.

- **Financial Responsibility:**
  If a family is not meeting financial responsibilities to the agency as outlined in the Financial Policy, the client may be discharged from therapy.
- **Poor Attendance:**
  Poor attendees may be discharged per the Attendance Policy.
- **Parent/caregiver Request:**
  Discharge will be completed upon caregiver request.
- **Agency Discretion:**
  The agency reserves the right to discharge any client at any time for any reason.

Changing Therapists

A child may, at one time or another, experience a change in his or her therapist. This may happen for any one of the following reasons:

- Therapist relocation
- Therapist illness or family emergency
- Scheduling issues in which the family requests a different day of the week or time of day for ongoing therapy sessions. We will accommodate changes as they arise; however, this will occasionally result in the child switching therapists.
- Lack of progress or 'connection' with the child's assigned therapist. Our number one goal is for the child to receive a maximum benefit from therapy. Occasionally, a child has a personality conflict with the assigned therapist or just does not develop a good working relationship with the assigned therapist. In cases like this, it is in the best interest of the child to re-assign them to a different therapist. Additionally, the child or therapist may reach a point where the child still needs therapy but is failing to make acceptable progress. The change to a new therapist may assist the child to begin making progress once again.
- Change in the specific therapist's schedule.

We make every effort to maintain continuity of care with as few changes as possible. When changes do arise, we will assist families in making the transition as smooth as possible.

Evaluation and Intervention:

Therapeutic evaluation and intervention are provided by state licensed and appropriately credentialed BCBA. Registered Behavioral Therapist(RBT) provide services under the supervision of our BCBA's. In a collaborative process with the child and his/her parent/Guardian, outcomes for therapeutic intervention are created and reassessed every 6 months to determine frequency and duration of service.

DIAPER CHANGING/POTTY TRAINING

I authorize Stepping Stone Kids Therapy staff to change my child, _____ diaper and assist with potty training if I am unavailable. I agree to supply an extra change of clothes, wipes, diapers and any other supplies needed. I release Stepping Stone Kids Therapy staff from all responsibility concerning this matter.

Childs Name: _____ Date: _____

Parent Signature: _____ Date: _____

NON-EVIDENCED BASED TREATMENTS

There may be times when you wish to explore other treatments for your child while he/she receives ABA services. Many services and treatments are evidenced based with ABA and we will make every effort to ensure that all professionals are working towards the same goals. However, some therapies and/or treatments may not be evidenced based treatment programs. In these cases, we will not be able to accommodate these treatments into your child's program. If you choose to use non-evidenced based treatments, you must let your Supervisor know when services begin and when there are changes in treatments. Please speak with your Supervisor for more details.

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HIPAA RELEASE FORM

Patient Name: _____ DOB: _____

RELEASE OF INFORMATITON

[X] I authorize the release of information including diagnosis, records: examination rendered to me and claims information. This information may be released to and from the staff and clinicians of Stepping Stone Kids Therapy along with the following people/places:

Name of Referring Doctor: _____

Specialty: _____

Phone: _____

Fax: _____

Name of Primary Doctor: _____

Specialty: _____

Phone: _____

Fax: _____

Specialty/Relationship: _____

Phone: _____

Fax: _____

This release of information will remain in effect until terminated by patient or guardian in writing

Printed Name of Parent/Gaurdian: _____

Relationship to patient: _____

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CONSENT FOR TREATMENT OF MINORS

This is to certify that the information on the intake forms are accurate to the best of my knowledge.

I give permission to Stepping Stone Kids Therapy to provide treatment for my child. I verify that all legal guardians are aware of and give consent for this treatment as well.

Printed Name of Parent/Guardian: _____

Relationship to Patient: _____

Signature of Parent/Guardian: _____

Date: _____

Guidelines for Parent Training

Your child's success in therapy is very important to the team at Stepping Stone Kids Therapy. You are an important member of the team. The following are recommendations to maximize your child's success in therapy.

1. Attend and be on time for all scheduled parent training appointments.
2. Parent are responsible to attend 2 trainings per month.
3. Parent training will be for one hour per training.
4. Arrive 10 minutes prior to the training to meet your child's therapist to review the session as well as participate in training.
5. If you must cancel, call 24 hours in advance when possible.
6. Communicate any concerns or observations regarding your child . If there are any questions or concerns about therapy,or interventions , please ask for your therapist or call BCBA for further clarification .
7. Follow recommendations and training tips that therapist provides to you on a regular basis.
8. Be mindful when dicussing your child's behaviors, major life stressors, or other dynamics with your childs therapist . We recommend discussing significant behaviors or concerns in private.

The above recommendations have been reviewed with me and I agree to follow these guidelines as outlined above.

Parent/Guardian Signature: _____ Date:_____