Bridge Behavior Consulting

"Creating lasting change with your family in mind"

Welcome!

Thank you for selecting us at Bridge Behavior Consulting for Applied Behavior Analysis (ABA) services to help you meet the needs of your family.

At Bridge Behavior Consulting we are an ABA program that supports the entire family with a commitment to our community. We believe in honoring and championing the unique strengths of each of our clients by building tailored programs that build skills while affirming neurodiversity. We believe in supporting all children in developing a healthy personal identity and positive sense of self.

The new client paperwork that you will be completing will help familiarize you with our policies and procedures regarding our ABA services. Additionally, the information you provide in this packet will help us in getting to know you and your child. Furthermore, the information will assist us in the planning and designing a highly customized ABA program for your child. Therefore, we ask that you please take your time to review the information in this packet and to answer each question as thoroughly as possible.

At Bridge Behavior Consulting, we would like to take this opportunity to thank you for entrusting us in providing services to you and your family. ABA treatment is about teamwork and we value you as part of the team, therefore, if at any time in this process you have any questions please feel free to contact us and we will be glad to help you.

Thank you again and we look forward to this journey with you and your child!

Sincerely,
Mariah Avery ,M.A. BCBA
Mariah Avery, MA, BCBA

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Terms of Service for Behavior Analytic Services

Service Delivery Agreement

Bridge Behavior Consulting agrees to provide Applied Behavior Analysis services (ABA) to your child to teach the skills necessary to promote independent functioning at home and in the community. These skills can include but are not limited to: language and communication, daily living, social and play, and self-help skills. The Board-Certified Behavior Analyst (hereafter identified as BCBA) agrees to complete an initial assessment and will provide a treatment plan with the specific number of hours per week recommended across a variety of treatment modalities to address your child's identified skill deficits. These can include but are not limited to: direct therapy, parent training, data analysis, and program and treatment plan development. This clinical recommendation is determined by the BCBA's evaluation of information provided in the initial assessment as the service delivery model that is able to make appropriate behavior change in the identified treatment plan goals.

The family understands that therapy outcomes are dependent upon several variables and success cannot be guaranteed. As with any type of therapy or intervention, there is risk associated with implementing a treatment protocol. Bridge Behavior Consulting (BBC) agrees to exercise the full extent of the Professional and Ethical Compliance Code for Behavior Analysts to minimize risks in treatment. The family understands that BBC has exclusive responsibility and authority to make all professional judgements and decisions with reference to the services rendered at the time of treatment. Caregivers understand that failure to adhere to treatment recommendations by the BCBA may impact the success of the child's progress and that caregivers are responsible for being a willing and active participant in the process. The family understands that continual non-compliance with adhering to treatment recommendations may result in termination of services.

Requests by the family to modify the hours of service in any way—either by increasing or decreasing the previously agreed upon hours of service—must be made in writing. The BCBA agrees to review hours change requests with the family to determine clinical need. The family agrees to maintain the current schedule for 30 days while any agreed upon adjustments are arranged.

The family or caregiver understands that a caregiver is required to be accessible when services are provided in the home.

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Consent to Communicate Electronically

I authorize communication with Bridge Behavior Consulting, staff using electronic mail or text messaging, and I realize the following risks and benefits apply.

Risks:

- Electronic communication may be viewed by third parties
- E-mail is sent across an open computer network and is generally unencrypted
- E -mail system could legally be read by the employer
- The confidentiality of electronic communication cannot be assured

Benefits:

- Use of electronic communication may eliminate the challenge of contacting individuals directly
- Non-urgent messages and questions may be communicated with less interruption than by phone
- E-mail allows a written record of communication, which can be a useful reference

Guidelines for Electronic Communication

Appropriate uses of e-mail for medical communication include:

- Address and telephone numbers of referrals
- Test results with interpretation and recommendation
- Questions and answers about issues discussed during a previous visit
- Questions and answers about new questions or concerns
- Verification of future appointment dates/times
- Other messages of a similar nature to the topics above

Electronic Communication SHOULD NOT be used to communicate:

- Emergencies and other time-sensitive issues
- Sensitive information that pertains to confidentiality and HIPAA laws

Additional Recommendation:

- Keep copies of emails you receive
- Printed e-mail messages will be kept on file

I / We understand the risks, benefits, and appropriate uses of electronic communication. I / We recognize that the confidentiality of any information discussed in electronic communication cannot be assured and I / We accept that risk. I / We understand that it is my responsibility to identify information that I / We expressly do not want communicated electronically. I / We agree to follow the guidelines listed above regarding appropriate and inappropriate uses of electronic communication.

Parent/Guardian #1: _____
(Print Name)

Parent/Guardian #1: _____ Date: _____ / _____ / _____
(Signature)

Parent/Guardian #2: _____
(Print Name)

Parent/Guardian #2: _____ Date: _____ / _____ / _____
(Signature)

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Financial Agreement

For insurance companies where there is no Single Case Agreement and Bridge Behavior Consulting is not an in-network provider, the family agrees to pay all fees for services rendered per the terms outlined below. In addition, Bridge Behavior Consulting offers access to many innovative services and procedures, some of them are deemed as "not covered" by insurance. You will be notified in advance and in writing if any of these services would be appropriate for your child. Should you participate in these services you agree to pay all fees as outlines below. Payments for services are billed per hour. Services rendered will be billed directly to the family weekly via invoice. Payment is due at the time of invoice.

The BCBA rate for out of network (private pay) services is $60.00 per hour.
The RBT rate for out of network (private pay) services is $35.00 per hour.

Families outside the service area (>25 miles outside of Bainbridge, Georgia) may be subject to milage fees of .56 cents per mile. This policy is dependent upon therapist availability in the client location and existing travel schedule.

If you have any questions regarding our Financial Agreement, please do not hesitate to discuss it with us by contacting admin@bridgebehaviorconsulting.com. If you have any questions or concerns regarding billing and insurance, please contact us at admin@bridgebehaviorconsulting.com.

I/We have carefully read and agree to this Fee Agreement and Payment Policy. I/We agree to abide by these terms outlined in this document.

Parent/Guardian #1: _____
(Print Name)

Parent/Guardian #1: _____ Date: _____ / _____ / _____
(Signature)

Parent/Guardian #2: _____
(Print Name)

Parent/Guardian #2: _____ Date: _____ / _____ / _____
(Signature)

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Cancellation/Missed Appointment Policy

Child Illness Policy

To ensure the health of the staff and other children with whom Bridge Behavior Consulting work, the family agrees to cancel a therapy session if your child is experiencing any of the following:

- Fever of 100.0 or higher
- Rash of unknown origin
- Diarrhea and/or vomiting within 24 hours of the scheduled session time

Therapy sessions may resume when:

- Fever is below 100.0 for at least 24 hours without medication
- Any rash has cleared and/or a physician recommends return
- Child has not vomited and/or had diarrhea for 24 hours
- Child is eating normally and able to retain food
- Cough and nasal discharge is not excessive

I/We understand Bridge Behavior Consulting's policy on client illness and agree to adhere to this policy.

Parent/Guardian #1: _____
(Print Name)

Parent/Guardian #1: _____ Date: _____ / _____ / _____
(Signature)

Parent/Guardian #2: _____
(Print Name)

Parent/Guardian #2: _____ Date: _____ / _____ / _____
(Signature)

Other Cancellations

Cancellation of a session should be made as soon as possible for illnesses or emergency appointments. If it is not possible to call 24-hours in advance, please contact the BCBA as soon as possible. Cancellations for extended days due to scheduled family vacations should be made with at least 14 days' notice.

Bridge Behavior Consulting recognizes family obligations may, at times, interfere with ongoing services. For these and all other occasions, the family will communicate with the BCBA as soon as plans are made in order for possible make-up sessions to be scheduled. If missed or canceled appointments begin to affect clinical progress or the successful implementation of programming, the BCBA will meet with the family to review the circumstances of these occurrences. Treatment progress will be reviewed with the family along with all missed/canceled appointments. At this time, a schedule will be arranged for future services and signed by both the caregivers and the BCBA. *Continued cancellations or missed appointments can result in a suspension or cancellation of services.*

How to Cancel Your Session

To cancel your scheduled appointments, please contact the BCBA directly via email, text or phone. If you are unable to reach the BCBA, leave a detailed voicemail. Emails and text messages are easy to refer back to and are preferred.

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Cancellation by Staff

If a BBC staff member cancels the scheduled appointment, the family will not be charged. The staff will notify the family of any interruptions in service as soon as this information is available and make up sessions will be scheduled whenever possible.

****COVID-19 Policy**

In order to ensure the safety of the children and families with which we work, Bridge Behavior Consulting will adhere to the Center for Disease Control's (CDC) recommendations to address COVID-19. Behavior staff will wear face masks whenever possible and sanitization procedures will be implemented before and after sessions. Sessions will be placed on hold until a child receives a negative COVID-19 test if there has been a known exposure or your child experiences the following:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle of body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

BBC will continue to update the policies related to COVID-19 using the latest CDC recommendations and families will receive written documentation of any changes made to the current policies.

Termination of Services

Parent's Rights

The family has the right to terminate services being provided by Bridge Behavior Consulting staff at any time with 30-day written notice to the BCBA (admin@Bridgebehaviorconsulting.com). Requests for changes in the scheduled therapy times should be addressed with the BCBA and these requests will be granted based on the availability of the staff. If a family requests a termination in services in order to seek ABA services with another provider, a 30-day written notice will be required. All efforts to assist in a successful transition to a new provider will be made, per code 2.15 of the Professional and Ethical Compliance Code for Behavior Analysts.

Provider's Rights

Bridge Behavior Consulting has the right to terminate the services being provided at any time. The appropriateness of behavior analytic services for your child will be evaluated every six months with each treatment plan update and reassessment. If at any point ABA services are deemed no longer appropriate, services will be discontinued within a 30-day period.

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Reporting Abuse

Bridge Behavior Consulting abides by Mandated Reporter Law - O.C.G.A. §19-7-5 (2016) of the Georgia Statutes. This mandate states the following:

Mandatory reports of child abuse, abandonment, or neglect; mandatory reports of death; central abuse hotline.

(1)(a) Any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, as defined in this chapter, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2).

(b) Any person who knows, or who has reasonable cause to suspect, that a child is abused by an adult other than a parent, legal custodian, caregiver, or other person responsible for the child's welfare, as defined in this chapter, shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2).

(c) Any person who knows, or has reasonable cause to suspect, that a child is the victim of childhood sexual abuse or the victim of a known or suspected juvenile sexual offender, as defined in this chapter, shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2).

(d) Reporters in the following occupation categories are required to provide their names to the hotline staff:

1. *Physician, osteopathic physician, medical examiner, chiropractic physician, nurse, or hospital personnel engaged in the admission, examination, care, or treatment of persons;*
2. *Health or mental health professional other than one listed in subparagraph 1.;*
3. *Practitioner who relies solely on spiritual means for healing;*
4. *School teacher or other school official or personnel;*
5. *Social worker, day care center worker, or other professional child care, foster care, residential, or institutional worker;*
6. *Law enforcement officer; or Judge.*
7.

If abuse or neglect by a parent, legal custodian, caregiver, or other person responsible for the child's welfare is suspected, the information will be immediately reported to the Department of Children and Families central abuse hotline.

Terms of Service Agreement

The family enters into this contract voluntarily with Bridge Behavior Consulting . This contract will remain in effect from this date _____/_____/_____, until either party wishes to terminate this agreement. Termination of this agreement should be done using the termination policy outlined above. The agreement of these terms of service supersedes all prior agreements, either written or oral, between the family and Bridge Behavior Consulting .

Patient: _____ **Date:** _____

_____ _____

Parent/Guardian Name (Print) **Parent/Guardian Signature**

_____ _____

Parent/Guardian Name (Print) **Parent/Guardian Signature**

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NOTICE OF PRIVACY PRACTICES
HIPAA Compliance Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY BEFORE SIGNING.

Understanding Your Health Information
When you begin working with Bridge Behavior Consulting a record of treatment is made. Typically, this record contains client history, assessment, medical information, diagnoses, treatment, a plan for future treatment, etc. This information, often referred to as your child's clinical record, serves as:

1. Basis for planning your care and treatment.
2. Legal document describing the care you received.
3. Means by which you or a third-party payer can verify that services billed were provided
4. A source of data for health officials charged with improving the health of the nation, or needed services for the area.
5. A tool by which future or continual services can be approved.
6. Understanding what is in this record will help you to ensure its accuracy, better understand who, what, when and why others may access you information and help to make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of Bridge Behavior Consulting the information belongs to you. You have the following rights:

A. Right to Request a Restriction
You have the right to request a restriction on our use and sharing of you protected health information. Bridge Behavior Consulting can deny the request if it is unreasonable or would be detrimental to your treatment.

B. Right to a Paper Copy of this Notice
You have a right to obtain a paper copy of this notice.

C. Right to Amend Your Health Information
You have the right to request an amendment to the health information we maintain about your child if you feel it is incorrect or incomplete for as long as the information is kept by Bridge Behavior Consulting . To request an amendment, you must submit a request in writing and state the reason that supports your request. The disputed information will remain in the record along with the amended information. Bridge Behavior Consulting may deny your request if the request is not submitted in writing, does not contain a reason to support the request, the information that is being questioned was not originated by Bridge Behavior Consulting , it is not part of the information which you are permitted to inspect or copy, or it is currently accurate and complete.

Health Care Insurance Providers
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, or copies of your child's entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Although all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. We will provide you with a copy of any report or form that we submit upon your request. By signing this Notice, you agree that we can provide requested information to your carrier for authorization of services and if/when you choose to file a claim for any services that we have provided to you or your child.

Others We May Share Your Information With

As required by law we will disclose your child's protected health information, even if you do not sign an authorization form, under the following circumstances:

1. Disaster Relief-to an agency organizing disaster relief efforts.
2. Public Health Activities-such as: reporting to a public health or government authority for preventing or controlling disease, injury, or reporting child abuse or neglect.
3. Food and Drug Administration (FDA)-concerning adverse events or problems with products or medications for tracking purposes to enable product recalls or to comply with other FDA requirements.
4. To notify a person who may have been exposed to a communicable disease or may otherwise be at-risk of contracting or spreading a disease or condition
5. For certain purposes involving workplace illnesses or injuries.
6. Reporting victims of abuse, neglect, or domestic violence—this information will be disclosed as required by law.
7. Judicial and Administrative proceedings—information may be disclosed in response to a court or administrative order, subpoena, discovery requests, or other lawful process. Efforts will be made to notify you about the request or to obtain an order or agreement protecting the information.
8. Health oversight activities—information may be disclosed to a health oversight agency for activities authorized by law, such as, audits, inspections, investigations, licensure actions or other legal proceedings.
9. Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations.
10. To avert a serious threat to health or safety-any disclosure would be made only to someone able to prevent the threat of safety to your child, the public or another person.
11. Research—only under your specific disclosure following written approval
12. Workers Compensation.
13. Law Enforcement—as required by law to comply with reporting requirements including, but not limited to: complying with court orders, warrants, subpoenas, summons, identifying or locating a fugitive, missing person or material witness, when information is requested about the victim of a crime if the individual agrees, to report information about a suspicious death, to provide information about criminal conduct occurring at the agency, or information about emergency circumstances about a crime.
14. National Security and Intelligence Activities, Protective Services for the President and others

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Records

We will review all testing results during our meetings with parents/guardians and offer you opportunities to review raw testing data with us. You will receive a written report that summarizes our 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 behavioral 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. We will forward copies of any reports or written summaries to others only with specific, written consent from you. Because of the proprietary nature of testing materials, we will release raw testing data only to other appropriately credentialed professionals (except as otherwise required by law).

Legal Proceedings

If you are involved in court proceedings and a request is made for information concerning our professional services, we cannot provide any information without your written authorization or a court order. However, a court order may force us to reveal information. In that case, we will reveal only the minimally acceptable amount of information. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

Professional Consultations

Board Certified Behavior Analysts and other professionals providing ABA services will routinely consult about cases with other professionals. Therefore, 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. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

Your Authorization is Required for Other Uses of Protected Health Information

Bridge Behavior Consulting will use and disclose protected health information (other than described in this Notice or required by law) only with your written authorization. You may revoke your authorization to use or disclose protected health information in writing, at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the purposes covered by the authorization except where we have already relied on the authorization.

Our Responsibility Regarding You/Your Child's Protected Health Information

Bridge Behavior Consulting is required by law to:

1. Maintain the privacy of your health information.
2. Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you if we are unable to agree to a requested restriction.
5. Inform you promptly if a breach occurs that may have compromised the privacy or security of your information.

We reserve the right to make changes to this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice.

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Any changes made will affect the protected health information we maintain at that time. We will provide a revised copy of the notice to parents/legal guardians upon request on or after the effective date of revision.

WE WILL NOT USE OR DISCLOSE YOUR CHILD'S PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION, EXCEPT AS DESCRIBED IN THIS NOTICE.

HIPAA Privacy Practices Agreement

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact Bridge Behavior Consulting. If you believe your privacy rights have been violated, you may file a complaint with Bridge Behavior Consulting or the U.S. Department of Health and Human Services. Complaints to DHHS can be filed in writing by mail, fax, or via their online portal found at https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html. These complaints must be filed within 180 days of when the act or omission of the complaint occurred. Bridge Behavior Consulting will not retaliate against your for filing a complaint.

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 above-mentioned HIPAA notice form described above. Consent by all parents/legal guardians (those with legal custody) is required before services are initiated.

Patient: _____ **Date:** _____

_____ _____

Parent/Guardian Name (Print) **Parent/Guardian Signature**

_____ _____

Parent/Guardian Name (Print) **Parent/Guardian Signature**

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TREATMENT CONTRACT

I/We are entering into this contract with Bridge Behavior Consulting voluntarily. This contract will remain in effect from this date, / / , until either party wishes to terminate this agreement by giving written notice.

I/We agree to cooperate with Bridge Behavior Consulting's efforts to provide services to my child and my family and I/we will participate in the treatment process and will follow through with any interventions recommended by Bridge Behavior Consulting. I/We understand that failure to comply with treatment and/or participate in parent training may be grounds for dismissal and termination of ABA services.

Bridge Behavior Consulting will supervise and monitor services provided to me and my child by individual therapists and consultants. These therapists and consultants are employees of Bridge Behavior Consulting and will be supervised accordingly. I/we understand that Bridge Behavior Consulting shall have exclusive responsibility and authority to make all professional judgments and decisions with reference to the ABA services rendered to me/us and our family.

I/we understand that a **minimum of 5%** supervision by a Board Certified Behavior Analyst is **required** to properly supervise the program, observe my child engaging in the recommended program, and make changes to his/her program when an RBT is on the treatment team. Additionally, that I/we must participate in a progress meeting at least once a month to review my child's progress and to discuss any changes to my child's program. I/We understand that there is a risk associated with any type of therapy or intervention, however, Bridge Behavior Consulting does everything possible to minimize risks.

I/We agree that to the fullest extent permitted by law, Bridge Behavior Consulting shall not be liable to the Client for any special, indirect, or consequential damages whatsoever, whether caused by Bridge Behavior Consulting's negligence, breach of contract, or other cause or causes whatsoever including, but not limited to, loss of behavioral consulting services and the costs related to locating a new provider of such consulting services. This does not include willful or intentional wrongs.

I also understand that therapy outcomes are dependent on several variables and success cannot be guaranteed. I understand that failure to adhere to treatment recommendations by Bridge Behavior Consulting staff may impact the success of my child's progress and that I am responsible for being a willing and active participant in this process. I understand that continual non-compliance with adhering to treatment recommendations may result in termination of services.

Executed this day of , .

Parent/Guardian #1: _____
(Print Name)

Parent/Guardian #1: _____ Date: _____ / _____ / _____
(Signature)

Parent/Guardian #2: _____
(Print Name)

Parent/Guardian #2: _____ Date: _____ / _____ / _____
(Signature)

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In-Take Questionnaire
-CONFIDENTIAL-

Please complete this intake questionnaire regarding your child. Feel free to add any additional information or attach additional reports that you think may be helpful for us in getting to know your child. Bridge Behavior Consulting views all of the information that you provide us with as strictly confidential. This information is helpful for us in developing an initial understanding of your child's needs and provides critical information for us to discuss with your insurance company to get authorization for services.

.

Today's Date: / /

GENERAL INFORMATION

Name of Person Completing this Form:

Relationship to Child/Adolescent:

Legal Name of Child/Adolescent:

Child/Adolescent's Date of Birth: / / Age:

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian 1 Name (First and Last Name):

Parent/Guardian 2 Name (First and Last Name):
Home Address:

,

Home Telephone: ( ) - -

Parent/Guardian 1 Employer: Cell Phone: ( ) - -

Parent/Guardian 1 Cell Phone: ( ) - - Email: _____

Parent/Guardian 2 Employer: Cell Phone: ( ) - -

Parent/Guardian 2 Cell Phone: ( ) - - Email: _____

Emergency Contact

Name Relationship

Phone Cell phone

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MEDICAL INFORMATION

Name of Physician:

Physician Address:

,

Physician Phone Number: ( ) - -

Child/Adolescent's Current Height: ft. in. Weight: lbs.

Which hand does your child/adolescent show dominance? ☐ Left ☐ Right ☐ No preference

Does your child/adolescent have any current health conditions, including infectious diseases?
☐ Yes ☐ No
* If yes, please explain below.

Please also provide the following:

Known Medical Conditions	Dates and Providers of Previous Treatment	Current Treating Clinicians	Current Therapeutic Interventions and Responses

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child/adolescent has had.

Does your child/adolescent have any vision problems? ☐ Yes ☐ No
* If yes, please explain below and if there are any treatments currently being used for correction.

Does your child/adolescent have any hearing problems? ☐ Yes ☐ No
* If yes, please explain below and if there are any treatments currently being used for correction.

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Does your child/adolescent have a history of seizures? ☐ Yes ☐ No

* If yes, please describe the types of seizures and current treatment.

Is your child/adolescent currently taking any medications? ☐ Yes ☐ No

* If yes, please provide the following information:

Name of Medication	Amount	How often is the medication taken?	When is the medication taken?	Please state any reactions or side effects your child/adolescent experiences from the medication.

Does your child/adolescent have any allergies to medications? ☐ Yes ☐ No

* If yes, please describe, including any adverse reactions:

Does your child/adolescent have any other allergies (seasonal, food, etc.)? ☐ Yes ☐ No

* If yes, please describe, including any adverse reactions and if any epi pen is needed:

Does your child/adolescent currently have a diagnosis? ☐ Yes ☐ No

* If yes, please provide the following information (continued on next page):

Diagnosis	Diagnosing Physician	Date Diagnosed

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CURRENT/PREVIOUS THERAPY PROVIDER INFORMATION

Please provide us with information regarding the following types of current or previous therapy providers and copies of any recent evaluations that indicate dates of previous treatment and therapeutic interventions and responses.

Does your child/adolescent currently receive any other services?

☐ Yes (Please provide information below.)

☐ No

Name of **Other Provider**:

Provider Address:

,

Provider Phone Number: ( ) - - Email:

EDUCATIONAL HISTORY

Please list all schools your child/adolescent has attended in order starting with the most current school.

Name of School	School System	Year(s)	Grade	Special Education Services
				☐ Yes ☐ No

Is your child/adolescent currently classified for special education services? ☐ Yes ☐ No

**** Please provide us with copies of any reports from evaluations that you may have, as well as a copy of the current 504 plan or IEP.***

FAMILY BACKGROUND

Does either parent/guardian's job require him/her to be away from home for long hours or extended periods of time that might prevent them from being involved in ABA services and parent training?

☐ Yes ☐ No

* If yes, which parent/guardian and for how long?

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Marital Status:

☐ Married
☐ Civil Union
☐ Remarried
☐ Divorced
☐ Separated
☐ Widowed
☐ Single
☐ Cohabitants

* If divorced, who has legal custody? Is it full or joint custody?
If there is a custody agreement please provide with the packet.

Are there siblings? ☐ Yes ☐ No

* If yes, please provide the following information:

	Name	Age	Relationship	Living in Home?	School	Grade
1.				☐ Yes ☐ No		
2.				☐ Yes ☐ No		
3.				☐ Yes ☐ No		

Please indicate and describe whether any of the siblings have any special needs, diagnoses, or concerns.

Are you also interested in seeking services for any of the siblings with special needs?

☐ Yes ☐ No ☐ Not applicable

*If yes, you will need to complete a new intake packet for that child.

Are there any other individuals residing in the house or that play a significant role in how this child is raised?

☐ Yes ☐ No

* If yes, please identify who else is involved in raising the child and their relationship to the child.

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PSYCHOLOGICAL HISTORY

Please indicate below whether or not there is a history of the following in your immediate family or in either biological parent's extended family.

Yes	**No**	
☐	☐	Autism Spectrum Disorders
☐	☐	Learning Problems/Disabilities
☐	☐	ADD/ADHD-Attention Problems
☐	☐	Clinical Depression
☐	☐	Bipolar Disorder
☐	☐	Behavior Problems in School
☐	☐	Anxiety Disorders (e.g., OCD, etc.)
☐	☐	Intellectual Disability
☐	☐	Psychosis/Schizophrenia
☐	☐	Substance Abuse/Dependence
☐	☐	Other Mental Health Concerns (Please specify:)

If yes, please indicate who in the family currently has or has had these diagnoses:

Has your child/adolescent had an outside psychological or psychiatric evaluation? ☐ Yes ☐ No

Has your child/adolescent ever been hospitalized for a psychiatric condition? ☐ Yes ☐ No

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child/adolescent.

BIRTH AND DEVELOPMENTAL HISTORY

Did the birth mother receive regular prenatal care? ☐ Yes ☐ No

Were there any complications with the pregnancy? ☐ Yes ☐ No
* If yes, please describe the complications below and treatment details.

Was birth at full term? ☐ Yes ☐ No
* If not, please provide details.

What was the type of delivery? ☐ Spontaneous ☐ Induced ☐ Vaginal ☐ C-Section

Were there any complications during delivery? ☐ Yes ☐ No
* If yes, please describe the complications below and treatment details.

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What was your child/adolescent's birth weight? lbs. oz.

Were there any concerns at birth? ☐ Yes ☐ No

* If yes, please describe the concerns and treatment details.

Were there any developmental milestones that your child was delayed in or did not achieve?

☐ Yes ☐ No

* If yes, please identify those milestones below.

CURRENT BEHAVIORAL CONCERNS

Please indicate if your child/adolescent engages in any of the following behaviors (check all that apply):

☐ Aggression (specify below)
- ☐ Hitting (e.g., punch, slap, etc.)
- ☐ Kicking
- ☐ Biting
- ☐ Pinching
- ☐ Head-butting
- ☐ Scratching
- ☐ Spitting
- ☐ Other (Please specify):

☐ Self-Injurious Behavior (specify below)
- ☐ Hitting self with hands or fists (Where on body?:)
- ☐ Kicking self (Where on body?:)
- ☐ Biting self (Where on body?:)
- ☐ Head-butting walls, windows, etc.
- ☐ Pulling teeth
- ☐ Scratching skin
- ☐ Cutting/burning
- ☐ Other (Please specify):

☐ Property Destruction (describe:)

☐ Eloping (i.e., running out of a building, room, vehicle, etc.)

☐ Sensory issues (describe:)

☐ Sexualized behaviors (describe:)

☐ Self-urinating/defecating

☐ Fecal smearing

☐ Rectal digging

☐ Difficulty with toileting

☐ Defiance or problems with authority

☐ Problems with eating

☐ Tantrums

☐ Screaming/yelling

☐ Vocalizations

☐ Repetitive behaviors

☐ Other (Please specify):

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Additionally, please indicate if your child is experiencing any of the following (check all that apply)?

☐ Isolated socially from peers
☐ Difficulty making friends
☐ Problems keeping friends
☐ Sleep problems (describe:)
☐ Bedwetting
☐ Fire setting
☐ Anxiety
☐ Sadness or depression
☐ Hallucinations
☐ Delusions
☐ Suicidal ideation/attempts
☐ Legal situations
☐ History of physical abuse
☐ History of sexual abuse
☐ Alcohol use/abuse
☐ Drug use/abuse including nicotine and/or illegal drugs (list drugs:)
☐ Difficulty concentrating

Are there any current or past relevant legal issues pending with your child/adolescent?
☐ Yes ☐ No * If yes, please describe below.

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

_____
_____
_____

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DISCIPLINE INFORMATION

Please rate what percentage of discipline is handled by each of the following:

Parent/Guardian 1: % Relationship to Child/Adolescent:
Parent/Guardian 2: % Relationship to Child/Adolescent:

What is typically used for disciplining your child/adolescent (e.g., timeout, assigning chores, physical/corporal punishment, etc.)?

Are there any spiritual beliefs or values that you think may impact how you provide discipline or behavioral support to your child? ☐ Yes ☐ No * If yes, please describe below.

Are there any cultural beliefs or values that you think may impact how you provide discipline or behavioral support to your child? ☐ Yes ☐ No * If yes, please describe below.

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REINFORCER CHECKLIST

Please review the following items and place a checkmark on the appropriate line indicating whether or not your child enjoys the items listed and would be motivated by them as a possible reward/reinforcer. Then list specific types or examples of each potential reinforcer.

Edible Reinforcers

☐ Yes
☐ No

If yes, please indicate types of edible reinforcers and provide examples for each:

☐ Salty:
☐ Sweet:
☐ Spicy:
☐ Sour:
☐ Beverages:
☐ Other (please specify):

***Does your child have any food allergies?** ☐ Yes ☐ No

* If yes, please describe, including any adverse reactions: _____

_____

Tangible Reinforcers

☐ Yes
☐ No

If yes, please indicate types of tangible reinforcers and provide examples for each:

☐ Toys:
☐ Games:
☐ Computer:
☐ iPad:
☐ Movies:
☐ TV shows:
☐ Music:
☐ Materials:
☐ Other (please specify):

Social Reinforcers

☐ Yes
☐ No

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If yes, please indicate types of social reinforcers and provide examples for each:

- ☐ Interacting with parents/guardians:
- ☐ Interacting with siblings:
- ☐ Interacting with other family members:
- ☐ Interacting with friends:
- ☐ High fives
- ☐ Verbal praise
- ☐ Other (please specify):

Activity Reinforcers

- ☐ Yes
- ☐ No

If yes, please indicate types of activity reinforcers and provide examples for each:

- ☐ Going out in the community:
- ☐ Singing songs:
- ☐ Playing teacher:
- ☐ Indoor activities:
- ☐ Outdoor activities:
- ☐ Other (please specify):

Automatic Reinforcers

- ☐ Yes
- ☐ No

If yes, please indicate types of automatic reinforcers and provide examples for each:

- ☐ Spinning:
- ☐ Staring at lights:
- ☐ Twirling hair:
- ☐ Rocking:
- ☐ Other (please specify):

Please provide any additional information on potential rewards/reinforcers for your child here:

Please record your ideal schedule below. Bridge Behavior Consulting will make every effort to accommodate your scheduling needs. Please note Fridays are exclusively utilized for staff development, documentation, and make up appointments. Should you not be able to attend a regularly scheduled session, you may request a Friday "make- up" session. This will be honored depending on staff availability.

Monday	Tuesday	Wednesday	Thursday

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Authorization for Release of Information and Records

Note: Use a new form for each provider.

I/We hereby **give permission and consent** to Bridge Behavior consulting to release and receive confidential information in my child's clinical record (e.g., behavioral assessments, behavioral data, medical records etc.) to the following practitioner:

Name:

Title:

Company/School/Practice:

Address:

,

Phone: ( ) - Email:

Client's Name: Date of Birth: / /

Parent/Guardian #1: _____

(Print Name)

Parent/Guardian #1: _____ Date: _____ / _____ / _____

(Signature)

Parent/Guardian #2: _____

(Print Name)

Parent/Guardian #2: _____ Date: _____ / _____ / _____

(Signature)