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**CLIENT INTAKE FORM**

Intake Date: \_\_\_\_\_ (for office use only)

**Client Information:**

**Client's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Caregiver/Parent I Name:** \_\_\_\_\_

**Relationship to Client:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Relationship to Client:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Work Number:** \_\_\_\_\_ **Highest Level of Education:** \_\_\_\_\_

**Caregiver/Parent II Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Work Number:** \_\_\_\_\_ **Highest Level of Education:** \_\_\_\_\_



**Collaborative  
SOLUTIONS**  
By Dr. Nikki Keefer & Assoc., Inc.  
*Your ABA Experts*

Phone: 407-489-2121  
Fax: 407-542-5158  
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**Emergency Contact:** \_\_\_\_\_

**Insurance Information:**

**Insurance Carrier:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Group ID:** \_\_\_\_\_

**Primary Insured Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Co-Pay:** \_\_\_\_\_ **Deductible:** \_\_\_\_\_

**Additional Insurance Info (ie: Out of pocket max)** \_\_\_\_\_

**Household Information:**

**Describe the Clients living situation. Please list all household members, their relationship, and ages.**

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**Diagnostic Information:**

**Diagnosis:** \_\_\_\_\_

**Diagnosis by:** \_\_\_\_\_

**Age at Diagnosis:** \_\_\_\_\_

**Date of Diagnosis:** \_\_\_\_\_

**Does the Diagnosis include a comprehensive evaluation?      Yes    No**

**Have we received a copy of the diagnosis and full comprehensive evaluation?      Yes    No**

*Most insurance companies will require submission of the ASD or other qualifying diagnosis by an MD with full comprehensive evaluation before they will approve an initial evaluation appointment. If you do not have this, please contact your Dr to get it as soon as possible. You may elect to begin services prior to receiving the diagnosis and getting insurance approval at our private pay rates.*

**If no, include please explain:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Does your insurance require a referral for ABA therapy?      Yes    No**

**If yes, do you have a referral for ABA therapy?      Yes    No**

**If yes, have we received a copy?      Yes    No**

**If your insurance requires a referral and you do not have one or we have not received a copy, include please explain:**

\_\_\_\_\_



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**Medical History:**

**Current Primary Care Physician or Pediatrician Name:** \_\_\_\_\_

**Group Name (if applicable):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Current Developmental Pediatrician:** \_\_\_\_\_

**Group Name (if applicable):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Current Neurologist:** \_\_\_\_\_

**Group Name (if applicable):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Current Psychologist:** \_\_\_\_\_

**Group Name (if applicable):** \_\_\_\_\_



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**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Current Psychiatrist:** \_\_\_\_\_

**Group Name (if applicable):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Current Speech Therapist:** \_\_\_\_\_

**Group Name (if applicable):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Current Occupational Therapist:** \_\_\_\_\_

**Group Name (if applicable):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Other Additional Medical Provider(s):**

**Specialty/Type:** \_\_\_\_\_

**Name:** \_\_\_\_\_



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**Group Name (if applicable):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Specialty/Type:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Group Name (if applicable):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Previous and/or Current Treatment(s) or Behavioral Interventions:**

**Are you currently receiving ABA services?    Yes        No**

**If yes, include please explain:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you ever received ABA services?    Yes        No**



**If yes, include please explain and describe past behavior interventions, strategies, and outcomes:**

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**Age During Treatment:** \_\_\_\_\_ **Duration of Treatment:** \_\_\_\_\_

**Additional Diagnosis Information:**

**Please list all current and past diagnosis information:**

Diagnosis	Age Diagnosed	Current Diagnosis?	
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No

**Does the client have any food allergies or special dietary needs?**    Yes    No

**If yes, please explain:**

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**Does the client have any drug/medication allergies? Yes No**

**If yes, please explain:**

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**Drug/Alcohol Screen (12yrs or older):**

**Does the client have a history of drug, nicotine, or alcohol use? Yes No**

**If yes, please explain:**

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**Has the client been exposed to drug, nicotine, or alcohol use? Yes No**

**If yes, please explain:**

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**Current Legal issues:**

**Are there any current legal issues relevant to treatment? Yes No**

**If yes, please explain:**

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**Infectious Disease Screen:**

**Does the client have any current infectious diseases? Yes No**



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**If yes, please explain:**

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**Family Medical History:**

**Mother (Relevant Dx/Treatments ie: MH/BH Dx):**

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**Father (Relevant Dx/Treatments ie: MH/BH Dx):**

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**Siblings (Relevant Dx/Treatments ie: MH/BH Dx):**

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**Other Relevant Information Regarding Family Medical History:**

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**Current Medications:**

**Please list all current medications:**

<b>Medication</b>	<b>Indication</b>	<b>Start Date</b>	<b>Dosage</b>	<b>Administration Info (days/times)</b>

**Other Relevant Information Regarding Medication:**

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**Describe why you have decided to seek ABA therapy at this time:**

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**Behavioral Problems/Targeted Risk Behavior:**

**Does or has the client in the past engaged in the following behaviors?**

<b>Behavior</b>	<b>Describe the behavior</b>	<b>When does it occur?</b>	<b>Where does it occur?</b>	<b>Who does it occur with?</b>	<b>How often does it occur?</b>	<b>Intensity</b>
<b>Aggression</b>						
<b>Self-Injury</b>						
<b>Property Destruction</b>						
<b>Elopement/ Running away</b>						
<b>Tantrums</b>						
<b>Screaming/Yelling</b>						
<b>Crying/Whining</b>						
<b>Inappropriate Social Behaviors</b>						
<b>Inappropriate Sexual Behaviors</b>						
<b>Non-Compliance</b>						
<b>Pica</b>						



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<b>Excessive Self Stim Behaviors (rocking, flapping, etc)</b>						
<b>Verbal Aggression</b>						
<b>Difficulty with Transitions</b>						
<b>Difficulty with Change</b>						
<b>Sensory Issues</b>						
<b>Obsessions/ Compulsions</b>						

**Other Relevant Information Regarding Behavior Problems:**



**Communication**

**What are the primary ways the client communicates with other people?**

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**Does the client follow spoken requests or instructions?**

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**Does the client respond to signed/gestural requests or instructions?**

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**Can the client imitate sounds, words, or phrases? If so, what are they?**

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**How does the client indicate “Yes” of “No” when asked if she or he wants something or wants to go somewhere?**

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**Independent Living Skills:**

**Describe current level of functioning and any issues in the following areas:**

**Toileting/Potty Training:**

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**Dressing:**

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**Hygiene skills (brushing hair/teeth, bathing, etc):**

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**Other Relevant Information Regarding Self-Help/Independent Living Skills:**

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**Reinforcers:**

**Please list the things that the individual likes:**

**Foods:**

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**Objects:**

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**Activities:**

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**Other:**

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**Educational Background (only applicable to school age children):**

Does the individual attend school? Yes No

School Name: \_\_\_\_\_

Address: \_\_\_\_\_

Grade: \_\_\_\_\_

Type of Classroom: \_\_\_\_\_

How long has the individual been attending school? \_\_\_\_\_

Currently performing on grade level? Yes No

Current IEP? Yes No

If yes, did we receive a copy? Yes No

Describe current accommodations, goals, and services being provided by the school:

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**Spiritual/Cultural Assessment**

Religious Preference? Yes No If yes, define \_\_\_\_\_

Are there any Spiritual Variables that may impact treatments? Yes No



**If yes, please explain:**

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**Are there any Cultural Variables that may impact treatments?    Yes    No**

**If yes, please explain:**

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**Goals and Objectives:**

Please list some goals that the client has for therapy:

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Please list some goals that parents/caregivers have for therapy:

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**Additional Relevant Information:**

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**Schedule of Availability:**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

This form may be submitted by email, fax, or at one of our locations during regular business hours.

Please include:

1. A full copy of the patient’s diagnosis that includes a comprehensive evaluation and any additional testing results that have been completed.
2. A front and back copy of your insurance card. We will respond to your request for an initial intake appointment once your packet is received and your insurance has been verified by your carrier. In some cases, this may take up to a week or more. After your insurance is verified and you are approved for an initial intake appointment our office will contact you by phone or email to set up your appointment.

**Email: [inquiries@collaborative-solutions.org](mailto:inquiries@collaborative-solutions.org)**

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# Client Demographic Form

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- 1 **Client Last Name:** \_\_\_\_\_
- 2 **Client Middle Name** \_\_\_\_\_
- 3 **Client First Name:** \_\_\_\_\_
- 4 **Suffix:** \_\_\_\_\_ (Jr, Sr, I., II, III, etc.)
- 5 **Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
- 6 **Residential Address:** \_\_\_\_\_
- 7 **City:** \_\_\_\_\_
- 8 **State:** \_\_\_\_\_
- 9 **Zip Code:** \_\_\_\_\_
- 10 **County:** \_\_\_\_\_
- 11 **Phone Number:** \_\_\_\_\_
- 12 **Gender:** \_\_\_\_\_
- 13 **Date of Birth:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 14 **Emergency Contact**
- 15 **Name:** \_\_\_\_\_
- 16 **Relationship:** \_\_\_\_\_
- 17 **Phone Number:** \_\_\_\_\_
- 18 **Parent/Guardian**
- 19 **Name(s):** \_\_\_\_\_
- 20 **Phone Number(s):** \_\_\_\_\_
- 21 **Work Phone Number(s):** \_\_\_\_\_
- 22 **Email Address(es):** \_\_\_\_\_
- 23 **Primary Diagnosis:** \_\_\_\_\_
- 24 **Insurance Company:** \_\_\_\_\_
- 25 **Insurance ID:** \_\_\_\_\_
- 26 **Religion:** \_\_\_\_\_  
(Agnostic, Atheist, Buddhist, Catholic, Christian, Hindu, Islam, Protestant, Jewish, Other (please specify), Unknown)
- 27 **Primary Language:** \_\_\_\_\_  
(English, Creole, French, German, Native American, Sign Language, Spanish, Telecommunication Device for the Deaf, Vietnamese, Unable to determine, Unknown, Other)

Signature \_\_\_\_\_

Date \_\_\_\_\_

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ( )	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>
c. EMPLOYER'S NAME OR SCHOOL NAME	d. INSURANCE PLAN NAME OR PROGRAM NAME	b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY GROUP OR FECA NUMBER
SIGNED _____ DATE _____		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		b. EMPLOYER'S NAME OR SCHOOL NAME
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		c. INSURANCE PLAN NAME OR PROGRAM NAME
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.
17a. _____ 17b. NPI _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
19. RESERVED FOR LOCAL USE		SIGNED _____
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
1. _____ 2. _____ 3. _____ 4. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____
25. FEDERAL TAX I.D. NUMBER SSN EIN		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
26. PATIENT'S ACCOUNT NO.		23. PRIOR AUTHORIZATION NUMBER
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		24. F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #
28. TOTAL CHARGE \$ _____ 29. AMOUNT PAID \$ _____ 30. BALANCE DUE \$ _____		1
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		2
32. SERVICE FACILITY LOCATION INFORMATION		3
33. BILLING PROVIDER INFO & PH # ( )		4
SIGNED _____ DATE _____		5
a. NPI _____ b. _____		6

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION