Rose Street Mental Health Care - Spectrum
4084 S. Regent Dr.
Wichita Falls, TX 76308
Phone: (940) 224-5297 Fax: (940) 228-4025

Date:	Informant Name:	Referred by:
Insurance Information		
Insurance Company:	Member ID:	Group Number:
Name of Policy Holder:	Policy Holder DOB:	Policy Holder Relationship to Client:
Policy Holder SSN:		
Secondary Insurance: Y/N (Please note, we are only able to bill your secondary insurance if we are in network for your secondary plan). Secondary Insurance Details:		
Tri-Care Specific: Reserve_____ Retired_____ Active_____		

Financial Agreement

New Patients approved for ABA therapy services are responsible for any and all charges not paid for by healthcare insurance payers (private or public). By signing this client agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Rose Street Mental Health Care - Spectrum for the services we provide to you. Following the receipt of your patient statement, please contact us to make payment arrangements. We accept cash, personal checks, money orders and credit cards.

Each healthcare insurance payer has different guidelines for allowing coverage of ABA therapy. It is helpful if you let us know your healthcare payer in advance when starting service so that we may find out if prior authorizations are needed. If your healthcare insurance payer is an insurance that we do not contract with, you are required to make self-pay arrangements for the usual and customary pricing of our services, please contact our administrative assistant Tara Batterman for those rates at tbatterman@rosestreet.org. We will provide you with a detailed invoice of services rendered on a monthly basis, so you may submit to your insurance. For non-contracted insurance payers and private pay clients, initial assessment fees will be collected at the time of assessment. Assessments typically last 4-10 hours based on complexity, and include 2 hours of report writing (please call for rates). For regularly scheduled ABA sessions, payment is due at time of service.

My signature below signifies that I have read and understand this client agreement for Rose Street Mental Health Care - Spectrum for ABA therapy services. I agree to the terms in this 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.

Signature of Guardian/Parent: _____ Date: _____

Printed Name of Guardian/Parent: _____

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Basic Identifying Information			
Client's Name:		Date of Birth:	Sex:
Home Address:	City:	State:	Zip:
Home Phone Number:		Cell Phone:	
Current School:	Does client have an IEP: Yes or No	Classroom Setting:	
Please Initial if you consent for RSS to: leave a message on home #_____ Leave message on cell#_____ text cell #_____ email_____			

Legal Guardian/Parent Name:		Date of Birth:	
Home Address:	City:	State:	Zip:
Home Phone Number:		Cell Phone:	
Relationship to the Client:		Email:	
Please Initial if you consent for RSS to: leave a message on home #_____ Leave message on cell#_____ text cell #_____ email_____			

Legal Guardian/Parent Name:		Date of Birth:	
Home Address:	City:	State:	Zip:
Home Phone Number:		Cell Phone:	
Relationship to the Client:		Email:	
Please Initial if you consent for RSS to: leave a message on home #_____ Leave message on cell#_____ text cell #_____ email_____			

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Household Information					
Client's legal guardians/parents are: Married_____ Separated_____ Divorced_____ other_____					
Please list other individuals that reside in the child's primary household or other relevant/immediate family members not listed above; *contact information is only required for additional caretakers/guardians;					
Name	**Age**	**Relationship**	***Phone #**	***Email**	***Address** **(if different)**

Please list the contact information of any approved caretakers that have permission to pick-up your child from therapy. You will be required to notify us of changes to this list prior to their release if a new caretaker has been assigned. The caretaker must have a valid driver's license and their vehicle must be suited with the appropriate child safety restraints before your child's dismissal or you will be called to pick your child up.

Name	**Age**	**Relationship**	***Phone #**	**Driver's License**	**Parent Signature**

Medical and ABA Treatment History			
Name of current pediatrician:	Phone Number:	Address:	
Allergies:			
Current Diagnosis (ASD):	Severity Level:	Date of Diagnosis:	Name and Credentials of Diagnostician:
Has your child ever been assessed for co-morbid disorders? Yes/No or unsure If yes please list any additional diagnosis:			
Does your child have any other medical diagnosis not listed above that we should be aware of? Yes/No If yes please explain:			

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Medical and ABA Treatment History : Medications Please include any medications, along with dosage		
Medication	Dosage	Prescribing Physician

Medical and ABA Treatment History : Other Services Received Speech Therapy, Occupational Therapy, Physical Therapy, Psychotherapy/Counseling		
Service Type	Intensity/Week	Response to Treatment

Medical and ABA Treatment History: ABA Current and Past Treatment History Please include all prior ABA services, as well as start date of current services			
Service Dates	Intensity/Week	Provider	Response to Treatment

Treatment Availability Please list the days and times your child will be available to attend therapy. Rose Street Spectrum utilizes a block scheduling system according to recommended treatment hours (ex. Mornings, Afternoons, After School, or Full Day)		
Day	**Beginning Time**	**End Time**
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

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Current Concerns

In your own words, please tell us what prompted you to seek ABA services.

Please check any of the following concerns that may have prompted you to seek ABA services:

___Social Skills Deficits
___Communication Delays
___Repetitive/Stereotyped Behaviors
___Echolalia
___Palilalia
___Hyperactive
___Impulsive
___Inattention
___Aggression (towards others or property)
___Self-Injurious Behavior
___Verbal Aggression
___Self-Regulation Problems
___Toileting Concerns
___Refusal/Defiance
___Feeding/Restrictive Eating Concerns
___Functional/Daily Living Skills Concerns
___Elopement
___Play Skills Deficits
___Depressed Mood/Anxiety
___Other:_____
___Other:_____
___Other:_____

Please check any of the following services you are interested in:

___1:1 Applied Behavior Analysis with your child
___Applied Behavior Analysis: Individual Parent Education
___School Services Advocacy and Assistance
___School Consultation (for Schools ONLY)
___Toilet Training
___Seasonal Programs
___Scholarship Programs
___Other:_____

**Applied Behavior Analysis that is Focused or Comprehensive may be determined by either the complexity of behaviors presented or severity of Autism Spectrum Disorder. This would determine the intervention necessary for your child to attend in order for he/she to gain the most from therapy.*

Additional Information

This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of time. Please feel free to add any additional information which you think may be helpful in understanding your child including any questions or concerns that you may have:

_____
_____
_____
_____
_____
_____
_____