

Registration Forms

The following is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment. Please feel free to add any additional information, which you think, maybe helpful in understanding your child. Autism Therapy Services of Moses Lake will hold information provided by you as highly and strictly confidential. Client information will only be released in accordance with HIPPA guidelines and as mandated by federal and state law. ATS is a Washington State Licensed Behavioral Health Agency.

Client Information			
Client's Name:			
Last	First	MI	
Date of Birth:	Current age:	Sex:	□Female
Address:	City:	Zip: _	
Diagnosis:	Date of Diagno	osis:	
Diagnosing	Primary Care		
Provider:	Provider Phone:		
Parent/Guardian and Family Inform	<u>mation</u>		
	Parent 1		
Name:	· · · · · · · · · · · · · · · · · · ·		
Last	Fir	rst	MI
DOB:	SSN:		
Address:	Same as Client	Does Not Reside	with Client
Primary Phone:	Secondary Phone:		
Email Address:		_	
Employer:	PROMONE IN THE PROPERTY OF THE		7000
Relationship to Client:			
	Parent 2		
Name:			
Last	Fir	st	MI
DOB:	SSN:		
Address:	□Same as Client □	Does Not Reside	with Client
Primary Phone:	Secondary Phone:		
Email Address:			
Employer:			
Relationship to Client:			



<u>Siblings</u>

☐ No Siblings	Sibling 1					
Name:		_ Sex:		Male		Female
DOB:	Lives with Client?	□ Yes		No		
Disabilities? None Yes, please list:			1 000			
	Maria di Santa da Cara de Cara	1)				
	Sibling 2					
Name:		Sex:		Male		Female
DOB:	Lives with Client?	□ Yes		No		
Disabilities? None Yes, please list:			- 40 1/2 /1/2			
			<i></i>		Acceptance of the second	
	Sibling 3					
Name:		Sex:		Male		Female
DOB:	Lives with Client?	☐ Yes		l No		
Disabilities? None Yes, please list:		Washington and the second				
				· 695		

For any additional siblings please use the back of this page.

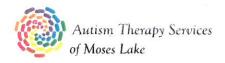
Thank you



Emergency Contact/Authorization for Client Pick Up or Drop Off

Contact 1

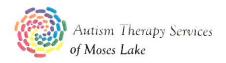
Name:	Sex:		Male [Female
Phone:	Lives with	Clie	nt?	Yes	□ No
Relationship to Client: The person listed above has permission to pick up or drop off the clien may also be contacted in the event of an emergency if ATS is unable to	t listed in the	nis pa	cket. Th	nis p	person
				O	
Contact 2					
Name:	Sex:		Male [Female
Phone:	Lives with	Clier	nt? 🗆 🤈	l'es	□ No
Relationship to Client:		11 mile			
The person listed above has permission to pick up or drop off the client may also be contacted in the event of an emergency if ATS is unable to	listed in the	is pa arent	cket. Th and or	is p gua	erson rdian.
Contact 3					
Name:	Sex:		Male [3	Female
Phone:	Lives with	Clier	it? 🗆 Y	es	□ No
Relationship to Client:					
The person listed above has permission to pick up or drop off the client may also be contacted in the event of an emergency if ATS is unable to	listed in th	is pa arent	cket. Th	is p guai	erson rdian.
Contact 4					
Name:	Sex:		Male []	Female
Phone:	Lives with	Clien	t? 🗆 Y	es	□ No
Relationship to Client:					
The person listed above has permission to pick up or drop off the client may also be contacted in the event of an emergency if ATS is unable to	listed in the pa	is pac	ket. Th	is p	erson dian.



Client Insurance Information

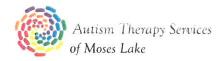
Primary Insurance Coverage

Medicaid: ☐ Yes	□ No
Name of Insurance:	
Name of Subscriber:	
Subscriber DOB:	Subscriber SSN:
Member ID Number: (Policy Number)	Group Number:
Co-Pay \$:	Provider One ID:
	Client Secondary Insurance Coverage
Medicaid:	□ No
Name of Insurance:	
Name of Subscriber:	
Subscriber DOB:	Subscriber SSN:
Member ID Number: (Policy Number)	Group Number:
Co-Pay \$:	Provider One ID:
Medicaid:	□ No
	Client Tertiary Insurance Coverage
Medicaid: ☐ Yes	□ No
Name of Insurance:	
Name of Subscriber:	
Subscriber DOB:	Subscriber SSN:
Member ID Number: (Policy Number)	Group Number:
Co-Pay \$:	Provider One ID:



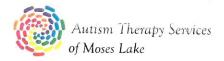
Clients Medical History and Health Information

Primary Care				
Provider (PCP):				
PCP Phone:				
PCP Address:				
City:				
Consent to Communicate with PCP? Yes	If no, please list reason ☐ No for refusal:			
Is the client taking any medications? ☐ No ☐	Yes, if yes dose:			
The Purpose of the medication:				
Any Over the Counter Medications? No				
Any Food Allergies? No Yes, if yes please list:				
Any Medication Allergies? No Yes, if yes please list:				
Is the client fully vaccinated? □ No □ Yes, if no please explain:				
Any other Medical issues or concerns that you may				



Clients Medical History and Health Information Continued

Past or current medical history and/or treatment for CHILD: Please check all that apply: ☐ Hospitalizations ☐ Surgeries ☐ Seizures ☐ Asthma ☐ Thyroid Problems ☐ High Fevers ☐ Head Injuries ☐ Anemia ☐ Digestive Disorder ☐ Migraines ☐ Diabetes ☐ Serious Illness ☐ Meningitis □ UTI ☐ Ear, Nose, & Throat Problems ☐ Other: Other Family member's medical diagnosis: Please check all that apply and to whom: (M=mother, F=Father, S=sister, B=brother, GF=grandfather, GM=grandmother) ☐ Chronic Pain □ Seizures ☐ Eating Disorder ☐ Anemia ☐ Sleep Difficulties ☐ Heart Disease ☐ Asthma ☐ Hypertension ☐ Liver Damage ☐ Stroke ☐ Kidney Disease ☐ Tuberculosis ☐ Food Allergies ☐ Cancer ☐ Thyroid Problems ☐ Diabetes ☐ Migraines ☐ Other Psychosocial History Is there a history in your immediate or in the mother's or father's extended family, including concerns for the child of the following? If yes, please list whom. Who: ☐ Autism Spectrum Disorder ☐ Learning problem/Disabilities ☐ ADHD-ADD-Attention Problems ☐ Depression & Manic Depression ☐ Behavior problems in school ☐ Anxiety disorder (OCD, Phobias, etc.) ☐ Cognitive impairment ☐ Psychosis/Schizophrenia ☐ Substance abuse/Dependence ☐ Other Mental Health Concerns:



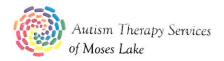
Clients Current School Placement

Name of School:			C
Teachers		Principal Name:	Current Grade
Schools		~.	Zip:
Phone: Days of]	Fax:	
In School	lWed □Th □F □ (
Special Services Provided?	None □ Yes If yes,	please list which so	ervices the client receives:
Clients Communications Sl How does your child communic		he wants? (please c	heck all that apply)
☐ Verbal (ONE WORD)	☐ Sign Language		Tablet (Prologue)
☐ Verbal (PHRASES/SENTENCES)	☐ Picture Communic	ation	Pulls people, points, or stands by what he/she wants.
☐ Communicates frequently	☐ Rarely Communica	tes	Needs prompting to communicate
☐ Cries or Whines	☐ Does not try to comneeded.	municate but care	givers give what is wanted and
☐ Other:			



of Moses Lak	ce				
Clients Self-Care Please list your chil	1 (25)	el of functioning in	n the following skill	S.	
Dressing	□ Completely	Independent	□Needs Some He	lp	□Needs Full Assistance
Eating	□ Completely	Independent	□Needs Some He	lp	□Needs Full Assistance
Drinking	□ Completely	Independent	□Needs Some He	lp	□Needs Full Assistance
Toileting	□ Completely	Independent	□Needs Some He	lp	□Needs Full Assistance
Brushing Teeth	□ Completely	Independent	□Needs Some He	lp	□Needs Full Assistance
	t, to some degr	ee, the kinds of be			heck those that you believe ildren of similar ages.
☐ Accidents (falls, l	bumps, into things)	☐ Reduced Attent	tion Span		
☐ Biting		☐ Reduced attent	ion to dangers		
☐ Crying/whinin	ng	☐ Refusing to foll	ow instructions		
☐ Destructive to	property	☐ Repeat activities periods of time. Ple			
☐ Does not learn experience	from	☐ Repetitive move rocking, spinning) Please	ements (hand waving, e Specify:		
☐ Drooling		☐ Running away/	bolting		
☐ Eating inedible	e objects	☐ Scratching			
☐ Flopping on th	e floor	☐ Self-harm (hittin	ng self)		
☐ Head banging		☐ Sleep Disturbar	aces		
☐ Hurt others		☐ Sloppy eating h	abits		
☐ Hyperactivity		☐ Spitting			
☐ Impulsivity		☐ Staring episodes	6 ("spacing out")		
☐ Interrupts freq	quently	☐ Tantrums			
☐ Kicking		☐ Unusual fears (please specify)		

☐ Low Frustratio	n Tolerance	☐ Verbal protestin	ng/refusal	☐ Poor	memory
☐ Nightmares		☐ Verbal threats			



CONSENT TO REGISTRATION AND INITIAL INTAKE

Clients Name:		Clients DOB:
	nerapy Services of Moses Lake Services Center 618 S Alder Street Moses Lake, WA 98837	Autism Therapy Services of Moses Lake Administrative Offices 615 S Division St., Suite A Moses Lake, WA 98837 Phone (509) 764-6644 Fax (509) 764-6676
	ats.moses	slake@gmail.com
Service Propose interviews and c	ed: Initial Intake meeting with child an observations will be used to develop ar	nd caregiver to which information derived from ny of the following:
⊠ Fur	nctional Behavior Assessment (FBA);	
⊠ Bel-	navior Change Plan;	
⊠ Init	ial Treatment Plan.	
@ @ @	of proposed services: Benefits-Services may lead to reduction Risks-Symptoms may worsen before in Alternatives-No services or the use of Anticipated results-Services will improte treatment.	nproving or may not improve at all
	I understand that the anticipated resu the following recommendation of sup I understand that certain records abou computerized form. I understand that records about my chevaluation and research with full prote	e those proposed services. consent at any time with written notice. Its of services are not guaranteed and are based on ervising clinicians. It my child's services shall be kept in written or aild's services may be audited and used for
Signatu	re Name of Parent/Legal Guardian	Relationship



Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective 1/1/2018, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use, and disclosure of your health records:

- 1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
- 2. We are required to abide by the terms of this Notice currently in effect.
- 3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain.

All changes in this Notice will be prominently displayed and available at our office.

There are several situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential health information for the following purposes. Primary care physician, teachers, speech therapists, occupational therapists, para-educators, etc. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, precertification and pre-authorization of services, or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation and general administrative functions. We may also use the



information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions. There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases, or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law-enforcement officials' information that you or another person is in immediate threat of danger to health or safety because of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. [Delete if inapplicable:] You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you. Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time.

In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney





Receipt of Notice of Privacy Practice

Client Name:	Date:				
My Signature on this form acknowledges that I have received Autism Therapy Services of Moses Lake, LLC. Notice of Privacy Practices. I understand that this document explains the ways that Autism Therapy Services of Moses Lake, LLC may use or disclose my child's personal information and my child's rights with respect to my child's service information.					
I have been provided with the opportunity to discuss information Autism Therapy Services of Moses Lake,					
Printed Name of Parent/Legal Guardian					
Signature of Parent/ Legal Guardian	Date				
For Autism Therapy Services of M	oses Lake, LLC Use ONLY				
Was the client/family provided with a copy of Autis					
Services of Moses Lake, LLC Notice of Privacy Pract					
If no, briefly describe efforts made to obtain the clie notice and explain why the client was not able or no					
Signature of admitting ATS staff person	Date				



as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain rights regarding your health record information, as follows:

- 1. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
- 2. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
- 3. You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
- 4. All requests for inspection, copying, and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
- 5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment, healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
- 6. If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice for your personal records.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.3

All questions concerning this Notice or requests made pursuant to it should be addressed to PRIVACY OFFICER, 615 S Division Street Suite A, Moses Lake, WA 98837.



Client Availability and Preferences

Client Name:	DOB:
Schedule Preference:	
Day Treatment Program Session 1 (Morning Session) _	9:00 am to 12:00 pm
Day Treatment Program Session 2 (Afternoon Session)	1:00 pm to 4:00 pm
Other Availability Needs: Please com	plete if special times are needed
Parent/Guardian Signature	Date

Moses Lake, WA 98837 Phone: (509) 764-6644 Fax: (509) 764-6676 ats.moseslake@gmail.com

Please see the resources recommended by our board-certified behavior analyst to help guide your understanding of ABA and Autism Spectrum Disorder. If you find you have additional questions, please call our office.

Resources:

This is a short video describing ASD in simple and effective terms.

https://www.youtube.com/watch?v=Ezv85LMFx2E

Center for Excellence in Developmental Disabilities: ADEPT TRAINING

http://www.ucdmc.ucdavis.edu/mindinstitute/centers/cedd/cedd_adept.html

These modules include videos and activities as well as quizzes to test knowledge of the material. Requires Adobe FLASH to view. Using Microsoft Edge is the easiest since it has the FLASH built in.

FREE RBT 40 Hour Online Training:

Free training course for anyone who desires training in ABA techniques.

https://autismpartnershipfoundation.org/courses/rbt/

"The POWER of Positive Parenting." By Dr. Glenn Latham

https://www.amazon.com/Power-Positive-Parenting-Wonderful-

Children/dp/1567131751/ref=sr 1 6?ie=UTF8&qid=1516129780&sr=8-6&keywords=positive+parenting

Autism Live YouTube Channel

https://www.youtube.com/channel/UCSR-PtIMWK7QzRHKDKJItRA

This channel is a great resource created by a parent of a child with ASD. She provides insights, invites experts in the field, and explains difficult concepts in a way everyone can understand.

UW Autism Center

https://depts.washington.edu/uwautism/

Autism Support Group of Grant County

Meetings: Second Thursday of the month.

https://www.facebook.com/autismsupportgroupofgrantcounty/

Parent to Parent Support Group

Please call the outreach coordinator for current information on meeting dates, times, and locations.

To be matched one on one to another parent with the same diagnosis/need as your child contact the

Outreach/Multicultural Specialist at adelgado@mlchc.org or call 509-764-7424

https://www.mlchc.org/content/parent-parent