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:** ☐Male ☐Female

Address: _____ **City:** _____ **Zip:** _____

Diagnosis: _____ **Date of Diagnosis:** _____

Diagnosing Provider: _____ **Primary Care Provider Phone:** _____

Parent/Guardian and Family Information

Parent 1

Name: _____
Last First MI

DOB: _____ **SSN:** _____

Address: _____ ☐Same as Client ☐Does Not Reside with Client

Primary Phone: _____ **Secondary Phone:** _____

Email Address: _____

Employer: _____

Relationship to Client: _____

Parent 2

Name: _____
Last First MI

DOB: _____ **SSN:** _____

Address: _____ ☐Same as Client ☐Does Not Reside with Client

Primary Phone: _____ **Secondary Phone:** _____

Email Address: _____

Employer:

Relationship to Client: _____

Siblings

☐ No Siblings

Sibling 1

Name: _____ Sex: ☐ Male ☐ Female

DOB: _____ Lives with Client? ☐ Yes ☐ No

Disabilities? ☐ None ☐ Yes, please list: _____

_____

_____

Sibling 2

Name: _____ Sex: ☐ Male ☐ Female

DOB: _____ Lives with Client? ☐ Yes ☐ No

Disabilities? ☐ None ☐ Yes, please list: _____

_____

_____

Sibling 3

Name: _____ Sex: ☐ Male ☐ Female

DOB: _____ Lives with Client? ☐ Yes ☐ No

Disabilities? ☐ None ☐ Yes, please list: _____

_____

_____

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

Thank you

615 S Division Street Suite A; Moses Lake, WA 98837
Phone: (509) 764-6644; Fax: (509) 764-6676
ats.moseslake@gmail.com

Emergency Contact/Authorization for Client Pick Up or Drop Off

Contact 1

Name: _____ Sex: ☐ Male ☐ Female

Phone: _____ Lives with Client? ☐ Yes ☐ No

Relationship to Client: _____

The person listed above has permission to pick up or drop off the client listed in this packet. This person may also be contacted in the event of an emergency if ATS is unable to reach the parent and or guardian.

Contact 2

Name: _____ Sex: ☐ Male ☐ Female

Phone: _____ Lives with Client? ☐ Yes ☐ No

Relationship to Client: _____

The person listed above has permission to pick up or drop off the client listed in this packet. This person may also be contacted in the event of an emergency if ATS is unable to reach the parent and or guardian.

Contact 3

Name: _____ Sex: ☐ Male ☐ Female

Phone: _____ Lives with Client? ☐ Yes ☐ No

Relationship to Client: _____

The person listed above has permission to pick up or drop off the client listed in this packet. This person may also be contacted in the event of an emergency if ATS is unable to reach the parent and or guardian.

Contact 4

Name: _____ Sex: ☐ Male ☐ Female

Phone: _____ Lives with Client? ☐ Yes ☐ No

Relationship to Client: _____

The person listed above has permission to pick up or drop off the client listed in this packet. This person may also be contacted in the event of an emergency if ATS is unable to reach the parent and or guardian.

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: ☐ Yes ☐ No

Name of Insurance: _____

Name of Subscriber: _____

Subscriber DOB: _____ Subscriber SSN: _____

Member ID Number: (Policy Number) _____ Group Number: _____

Co-Pay $: _____ Provider One ID: _____

Medicaid: ☐ Yes ☐ 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 Fax: _____

PCP Address: _____

City: _____ State: _____ Zip: _____

Consent to Communicate with PCP? ☐ Yes ☐ No If no, please list reason for refusal: _____

_____

Is the client taking any medications? ☐ No ☐ Yes, if yes dose: _____

The Purpose of the medication: _____

Any Over the Counter Medications? ☐ No ☐ Yes, if yes please list: _____

_____

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 have: _____

_____

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)

- ☐ Seizures _____
- ☐ Chronic Pain _____
- ☐ Eating Disorder _____
- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Sleep Difficulties _____
- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Stroke _____
- ☐ Liver Damage _____
- ☐ Kidney Disease _____
- ☐ Cancer _____
- ☐ Tuberculosis _____
- ☐ Food Allergies _____
- ☐ Migraines _____
- ☐ Diabetes _____
- ☐ Thyroid Problems _____
- ☐ 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: _____ Current Grade _____

Teachers Name: _____ Principal Name: _____

Schools Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Days of Attendance: ☐ M ☐ Tu ☐ Wed ☐ Th ☐ F ☐ OTHER: _____

In School Hours: _____

Special Services Provided? ☐ None ☐ Yes If yes, please list which services the client receives:

_____

_____

_____

Clients Communications Skills

How does your child communicate or tell you what he/she wants? (please check all that apply)

☐ Verbal (ONE WORD)

☐ Verbal (PHRASES/SENTENCES)

☐ Communicates frequently

☐ Cries or Whines

☐ Sign Language

☐ Picture Communication

☐ Rarely Communicates

☐ Tablet (Prologue)

☐ Pulls people, points, or stands by what he/she wants.

☐ Needs prompting to communicate

☐ Does not try to communicate but caregivers give what is wanted and needed.

☐ Other: _____

Clients Self-Care Skills

Please list your child's current level of functioning in the following skills.

Dressing	☐Completely Independent	☐Needs Some Help	☐Needs Full Assistance
Eating	☐Completely Independent	☐Needs Some Help	☐Needs Full Assistance
Drinking	☐Completely Independent	☐Needs Some Help	☐Needs Full Assistance
Toileting	☐Completely Independent	☐Needs Some Help	☐Needs Full Assistance
Brushing Teeth	☐Completely Independent	☐Needs Some Help	☐Needs Full Assistance

Clients Home/Play/Social Behaviors

All children exhibit, to some degree, the kinds of behaviors listed below. Please check those that you believe your child exhibits to an excessive or exaggerated degree to compared to other children of similar ages.

☐ Accidents (falls, bumps, into things)

☐ Biting

☐ Crying/whining

☐ Destructive to property

☐ Does not learn from experience

☐ Drooling

☐ Eating inedible objects

☐ Flopping on the floor

☐ Head banging

☐ Hurt others

☐ Hyperactivity

☐ Impulsivity

☐ Interrupts frequently

☐ Kicking

☐ Low Frustration Tolerance

☐ Nightmares

☐ Reduced Attention Span

☐ Reduced attention to dangers

☐ Refusing to follow instructions

☐ Repeat activities for prolonged periods of time. Please specify: _____

_____

☐ Repetitive movements (hand waving, rocking, spinning) Please Specify: _____

_____

☐ Running away/bolting

☐ Scratching

☐ Self-harm (hitting self)

☐ Sleep Disturbances

☐ Sloppy eating habits

☐ Spitting

☐ Staring episodes ("spacing out")

☐ Tantrums

☐ Unusual fears (please specify)

_____

_____

☐ Verbal protesting/refusal

☐ Verbal threats

☐ Poor memory

615 S Division Street Suite A; Moses Lake, WA 98837
Phone: (509) 764-6644; Fax: (509) 764-6676
ats.moseslake@gmail.com

CONSENT TO REGISTRATION AND INITIAL INTAKE

Clients Name: _____ **Clients DOB:** _____

Autism Therapy 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.moseslake@gmail.com

Service Proposed: Initial Intake meeting with child and caregiver to which information derived from interviews and observations will be used to develop any of the following:

☒ Functional Behavior Assessment (FBA);

☒ Behavior Change Plan;

☒ Initial Treatment Plan.

Benefits, risks of proposed services:

- **Benefits**-Services may lead to reduction of symptoms
- **Risks**-Symptoms may worsen before improving or may not improve at all
- **Alternatives**-No services or the use of other types of services
- **Anticipated results**-Services will improve the possibility of positive outcome after treatment.

For the person(s) providing consent:

- I hereby consent to the services proposed above for my child.
- I was able to ask questions and receive those proposed services.
- I understand that I may withdraw my consent at any time with written notice.
- I understand that the anticipated results of services are not guaranteed and are based on the following recommendation of supervising clinicians.
- I understand that certain records about my child's services shall be kept in written or computerized form.
- I understand that records about my child's services may be audited and used for evaluation and research with full protection of confidentiality.
- I have been provided with a copy of Autism Therapy Services of Moses Lake's Notice of Privacy Practices.

_____ _____

Signature Name of Parent/Legal Guardian **Relationship**

Autism Therapy Services
of Moses Lake

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

Autism Therapy Services
of Moses Lake

615 S Division Street Suite A
Moses Lake, WA 98837
Phone: (509) 764-6644 Fax: (509) 764-6676
autsimtherapyservicesmoseslake@gmail.com

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 any concerns about the privacy of my child's information Autism Therapy Services of Moses Lake, LLC has during the provision of services.

_____
Printed Name of Parent/Legal Guardian

_____ _____
Signature of Parent/ Legal Guardian Date

For Autism Therapy Services of Moses Lake, LLC Use ONLY		
Was the client/family provided with a copy of Autism Therapy Services of Moses Lake, LLC Notice of Privacy Practice?	☒Yes	☐No
If no, briefly describe efforts made to obtain the client's acknowledgement of receipt of the notice and explain why the client was not able or not willing to sign this form:		
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.

(Keep for your files to use when needed)

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 complete if special times are needed**

_____

_____

_____

_____ _____

Parent/Guardian Signature Date

Autism Therapy Services
of Moses Lake

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