Abilities First
Intake Form Instructions

- Use the fillable form below to input all the information. Leaving critical information blank can slow down your child's intake.

- Skip fields where no information is needed.

- In fields that require your signature, just type your full name. This will represent your signature and you will sign a form to this effect when you finalize your paperwork onsite.

- Once you have filled in all the relevant fields, save the document in a place where you know you can retrieve it.

- Attach the completed form to an email and email it to intake@abilitiesfirst.org. The subject line should read, "Intake form"

- You should receive confirmation from Abilities first within two business days. If you have not received confirmation, please follow up with a call to 513-423-9496 x 251.

- If you need any help filling out the forms, please don't hesitate to reach out for help. You can also download and print this form from our website if that is easier.

Abilities First Pediatric Therapies/Autism Learning Center

GENERAL INFORMATION

Date: _____

Child's Name: _____
Last First Middle

Male _____ Female _____

Child's Social Security # _____ Birthdate: _____

Referring Physician: _____

Diagnosis: _____

Parent/Guardian - Mother: _____ Birthdate: _____
Parent/Guardian - Father: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip code: _____ County _____

Home Phone: _____ Cell Phone: _____
Work Phone: _____ Cell Phone: _____
E-mail address: _____

If different from Parent/Guardian:
Birth Mother's Name: _____ Birthdate: _____
Birth Father's Name: _____ Birthdate: _____

What is the primary funding source for therapy services for your child?
__ Insurance __ Medicaid __ CareSource __ BCMH __ Self

Primary Insurance Company:_____

Responsible Person: _____

Social Security #: _____ Employer: _____

Policy #: _____ Group #: _____

Secondary Insurance Company: _____

Responsible Person: _____

Social Security #: _____ Employer: _____

Policy #: _____ Group #: _____

Race:
☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Multi-Racial
☐ Native Hawaii/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other

Ethnicity: __ Hispanic __ Non-Hispanic

Household Income:
☐ $0-$9,999 ☐ $10,000-$14,999 ☐ $15,000-$24,999
☐ $25,000-$34,999 ☐ $35,000 & Above ☐ Unknown

Abilities First Pediatric Therapies

Client: _____

Pediatric Therapies
Financial Agreement

I understand that Abilities First files insurance claims on my behalf as a customer service. I agree to assist Abilities First in providing supportive documentation as request by my insurance carrier. I agree that all payments from my insurance company, Medicaid, CareSource and/or BCMH will be paid directly to Abilities First.

I understand that I am responsible to provide immediate notification to the Therapy Services Coordinator of any change in insurance policy coverage, eligibility and/or insurance carrier.

I understand that I am expected to maintain a current Medicaid, CareSource and/or letter of eligibility from BCMH, if applicable, during the time therapy services are provided. In the event I do not receive my monthly Medicaid card renewal, I will immediately notify the Therapy Services Coordinator.

I understand that I am responsible to provide the Therapy Services Coordinator with a copy of my insurance cared, Medicaid, CareSource and/or BCMH letter of eligibility at the beginning of every year.

I understand payment can be made by cash, check, debit card and/or credit card (Visa, MasterCard, Discover and American Express).

I understand delinquent payment may result in suspension of therapy service and account may be turned over to collection agency.

I understand a $30.00 charge will be added to my account for any check returned from the bank.

I understand that I can be provided a monthly statement indicating the services rendered, date and amount billed for such services. In the event my insurance denies payment, I accept full responsibility for the balance due within 60 days from the date of service.

_____	_____	_____
Signature of Responsible Party	Relationship to Client	Date
_____	_____	_____
Witness	Title	Date

Abilities First Pediatric Therapies/Autism Learning Center

Consent Form

Please check agree or disagree in each section and then sign bottom of form.

Consent for Treatment:

_____ Agree _____ Disagree

I give permission for my child, _____,
to receive evaluation/screening/treatment by PT/OT/SLP at Abilities First.

Consent for Observation:

_____ Agree _____ Disagree

I give permission to the Pediatric Therapies program to permit students in the health professions, technicians and other such persons as the staff may deem fit to observe or be supervised in treating my child during an evaluation/ screening and/or treatment session. It is understood that any information revealed during such observations and/or supervisions will be held in strict confidence.

Consent to Photograph/Video for Abilities First public relations including social media:

_____ Agree _____ Disagree

_____
Parent/Guardian

_____
Date

Abilities First Pediatric Therapies/Autism Learning Center Case History Date ___/___/___

Identifying Information:
Child's Name:

_____
Last First Middle
Sex: ___ Male ___ Female Name child prefers: _____ Birthdate: ___/___/___
Diagnoses: _____
With whom does your child live? _____
Relationship to child: _____
Name of legal guardian:_____

Sibling Information:
Name: _____ Age: _____ Do they live in same household? _____
Name: _____ Age: _____ Do they live in same household? _____
Name: _____ Age: _____ Do they live in same household? _____
Name: _____ Age: _____ Do they live in same household? _____

School Information:
In what school district do you live? _____
If attending school/pre-school/day care: What is the name of the school? _____
Does your child have an IFSP/IEP or service plan? _____ Yes _____ No

Birth History:
Length of Pregnancy _____ Birth Weight: _____
Type of Delivery: _____Vaginal _____C-Section
Complications before/during/after delivery: _____
_____
_____

Child's Developmental History:
How was your child fed as an infant? _____ Breast _____ Bottle _____ G-tube
When were baby foods added? _____ When were table foods added? _____
Was there normal weight gain? _____ Yes _____ No Does your child eat well? _____ Yes _____ No
Were there any problems such as vomiting, diarrhea, constipation or colic? ___ Yes ___ No
If yes, please indicate which one(s): _____
Nutrition: Describe briefly typical breakfast/lunch/dinner: (if a concern) _____
_____
_____

Give the age, or approximate age at which your child did the following:

Motor	Age		Motor	Age
Lifted head when on stomach			Walked alone	
Balanced head when propped on elbows			Climbed steps	
Rolled over (stomach to back)			Ran	
Rolled over (back to stomach)			Rode tricycle	
Sat with support			**Language**	**Age**
Sat alone			Babbled	
Crawled			Said single words	
Stood with support			Could be understood	
Stood alone			Said 3-word sentences	

Self Help	Age		Self Help	Age
Drank from cup			Ate with assistance	
Feed self finger foods			Toilet trained: bladder	
Feed self with spoon			bowel	

Recent Medical History:

List all medications your child is currently taking:

Medication/Supplement - Purpose	Medication/Supplement - Purpose

List all hospitalizations, chronic illnesses, serious injuries which may have been associated with your child's difficulties:

Age	Reason

Child has or has had seizures. _____Yes _____No
Child has allergies to the following: _____
Child's immunizations are up to date? _____ Yes _____ No If no, give reason: _____
Child has previously received therapy? _____ Yes _____ No _____PT _____OT _____ST
Child received a vision test? ___ Yes ___ No When/Where? _____
Results: _____
Child has received hearing test? _____ Yes _____ No When/Where? _____
Results: ___ Normal or Hearing Loss: _____ Mild _____ Moderate _____ Severe
Child has frequent ear infections? ____ Yes _____ No
Child has or had PE tubes? _____ Yes _____ No If yes, when were they inserted? _____

Current physicians involved in your child's care:

List all of child's physicians (i.e. Orthopedic, Neurologist)

Doctor	Specialty	Date last seen

Habits and Personality:

What does your child like to do?_____
_____
How does your child express unhappiness, anger, frustration? _____
_____
Sleep patterns: How long? _____ Where does your child sleep? _____

Parent Concerns/Expectations:

_____
_____
_____
_____

If you need more space – Please write on back of second page

Emergency Information

Child's Name: _____ Parent/Guardian: _____

Street: _____ Work Phone: _____

City/State/Zip: _____ Parent/Guardian: _____

Home Phone: _____ Work Phone: _____

Part 1
Please list an emergency contact other than parent/guardian:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Preferred Hospital: _____

Preferred Doctor: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Part 2
Authorization to seek emergency health care in the event a parent or guardian cannot be reached.

In the event that reasonable attempts made to contact me at the numbers listed above have been unsuccessful, I herby give my consent for the administration of any treatment deemed necessary by the above doctors. In the event the above doctors are not available, another licensed doctor may provide treatment. I also authorize for my child to be transported to the above named hospital or any hospital this accessible.

This authorization does not cover major surgery unless the doctor deems it as a life threatening decision.

Parent/Guardian Signature: _____ Date: ___/___/___

Part 3
Do not complete Part 2 if you chose to complete Part 3.

I do not give consent for emergency medical treatment of my child. In the event I cannot be contacted in an emergency situation, I wish that no action be taken or (actions you wish to be taken):
_____
_____

Parent/Guardian Signature: _____ Date: ___/___/___

IMPORTANT

ABILITIES FIRST PEDIATRIC THERAPIES ATTENDANCE POLICY

It is our goal to assist your child in making as much progress as possible. In order for that to happen, consistent attendance is mandatory. We ask for your commitment to keeping your therapy appointments as scheduled.

What is my responsibility in canceling an appointment?

You are responsible for calling the Therapy Service Coordinator, Bettie Rountree, at 513-423-9496 x 251 or 800-378-8612 x 251 if you need to cancel an appointment. The call must be received a minimum of 4 hours in advance of the scheduled appointment. If the coordinator is not available, you may leave a message on the voice mail.

What is considered an excused or unexcused absence?

We understand people cancel or miss appointments for a variety of reasons. The following are the definitions of excused and unexcused absences:

> **Excused Absence:** An illness, accident or other emergency situation, or a call at least 4 hours in advance of your appointment.
>
> **Unexcused Absence:** Not calling to cancel your appointment, not showing up for your appointment, or a non-emergency situation in which a call is received less than 4 hours in advance of the appointment.

What happens if I no show for an appointment?

You will be charged a $25.00 no show fee.

Will my appointment be rescheduled?

When you call, we will make every effort to reschedule your appointment. If your child's therapist is not available, we may reschedule the appointment with another therapist.

What happens after six (6) excused absences?

If your child has six (6) excused absences within the six (6) month period (April to September or October to March) your child may lose their appointment time and be taken off the therapist's schedule. As this point, their name may be placed at the bottom of the waiting list and called as availability arises.

What if my child is sick for three (3) weeks in a row (i.e. – chicken pox) or we are on vacation?

This will be considered as one (1) excused absence since it all stems from the same issue.

What happens after three (3) unexcused absences?

If your child has three (3) unexcused absences within the six (6) month period (April to September or October to March) your child will lose their appointment time and be taken off the therapist's schedule. At this point, their name may be placed at the bottom of the waiting list and called as availability arises.

What happens if I am late for an appointment?

If you are late by one half of the scheduled appointment (i.e. 15 minutes late for a 30-minute appointment) no therapy will be provided that day. If you are late less than one half of the appointment time, your session will still be ended at the scheduled time.

Will I be notified if I am about to be taken off the therapist's schedule?

Yes, you will be notified by phone and/or mail.

We appreciate your support and commitment to follow this policy and ensure consistent treatment for your child.

Client Name: _____

Parent/Guardian Signature _____ Date _____

AF Employee witnessed _____ Date _____

Abilities First HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health and education information.

The notice contains an individual's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified and asked to sign an update.

You have the right to restrict how your protected health and education information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare and education information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health and education information may be disclosed or used for treatment, payment, educational purposes or healthcare operations.
- Abilities First reserves the right to change the privacy policy as allowed by law.
- You have the right to restrict the use of the information, but Abilities First does not have to agree to those restrictions.
- You have the right to revoke this consent in writing at any time and all full disclosures will then cease.
- Abilities First may condition receipt of treatment upon execution of this consent

1. May we phone, e-mail or send a text to confirm appointments? ☐ Yes ☐ No
2. May we leave a message on your answering machine or cell phone? ☐ Yes ☐ No
3. May we discuss your child's medical condition with any member of the family? ☐ Yes ☐ No
4. May we discuss your child's education records with any member of the family? ☐ Yes ☐ No
   (Question 4 for Autism Learning Center Students Only)

Child's Name _____ Date of Birth _____

This consent signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Abilities First Pediatric Therapies/Autism Learning Center

Authorization to Pick up Child

Child's name: _____ Date of Birth ___/___/___

The following individuals are authorized to pick up the above named child.

Name	Relationship to Child	Phone	Alternate Phone	Date added or deleted
	Parent or Guardian			

Please sign on the line below:

_____ _____ _____

Parent/Guardian Relationship to Child Date