office.childenrichmentcenter@gmail.com
Fax: 858-521-8173
www.childenrichmentcenter.org

Requirements for an Initial Intake

1. Complete Intake form and provide the other documents listed
    - Attached consent form for intake
    - Provide a report/evaluation confirming an diagnosis Autism, ADHD, or other developmental disorder
    - Provide any recent evaluations the child has had completed (school IEP, speech, OT, neurological, etc.)
    - Physician's letter of medical necessity (from Primary Physician)
    - Current medical records if the child is on prescription medication
    - Copy of insurance card(s)

2. If insurance is involved then, your insurance pre-approval is required prior to any evaluation, therapy, or other service being provided. Please provide documentation from the insurance company that the Initial Intake is Pre-approved so that you do not have to pay the bill.
    - Kaiser Permanente requires a referral and the Autism Diagnosis to be sent from your child's primary care physician to both Kaiser Permanente and we also need them sent to Child Enrichment Center: Fax: (858) 521-8173.
    - All other insurances are on a case-by-case
    - Premera does not require pre-authorization for mental health counseling or one for ABA therapy if your plan provides ABA.
    - You will need to find out if ABA is covered under your Insurance plan.
    - Medicaid (Amerigroup and Community Health Plan)require the Diagnosis Report and a Letter of Medical Necessity be sent to them prior to retaining services.

All co-pays and deductibles are due in full.

Private Insurance Billing and Medicaid
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Office phone 509-420-3442

3. Intake Interview (2 hours) and possible observation in natural environment (1 hour).
4. Functional assessment/Treatment plan-develop treatment goals and agreement signatures by providers and parent to implement plan.
5. Arrangement of therapy schedule.

After completion of this form, please fax, email or mail it back to Child Enrichment Center along with a copy of required paperwork as state above. Once all documents are received our Office Manager (confirm submission) office.childenrichmentcenter@gmail.com will contact you to set up an initial intake with a Counselor or Behavior Analyst depending on your insurance coverage. Completion of this form does not guarantee services. For more information please visit our website at www.childenrichmentcenter.org.

Child Enrichment Center
Phone: 509-420-3442
Fax: 858-521-8173
1950 Keene Rd, Building K
Richland, WA 99352

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Intake Form

Please Complete the whole form

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, may be helpful in understanding your child. Child Enrichment Center will hold information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law.

IDENTIFYING INFORMATION

Child's Name: _____
(Last) (First) (MI)

Date of Birth: _____ Current Age: _____ Sex: □ Male □ Female

Address: _____
City State Zip code

Diagnosis: _____

Last Diagnosis: _____

DSM Code (if known): _____ Date of diagnosis: _____

Diagnosed by: _____

PARENT/GURDIAN AND FAMILY INFORMATION

Mother's name: _____

Address: _____
City State Zip code

Home Phone: _____ Cell Phone: _____

Occupation: _____ Email Address: _____

Father's name: _____

Address: _____
City State Zip code

Home Phone: _____ Cell Phone: _____

Occupation: _____ Email Address: _____

Siblings: (use back of sheet for more space)

1. _____
(Name) (Sex) (Age) (Disability)

2. _____

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(Name) (Sex) (Age) (Disability)

3. _____
(Name) (Sex) (Age) (Disability)

Other persons living in the home: _____

Other family information: _____

INSURANCE INFORMATION

Name of Insurance Carrier: _____

Name of Beneficiary or Sponsor: _____ DOB: _____
(Name of child or parents insurance is covered under)
Member ID#:_____ Group #: _____
Co-pay $:_____ Deductible $: _____

SECONDARY INSURANCE:
Name of Secondary Insurance Carrier: _____

Name of Beneficiary or Sponsor: _____DOB: _____
(Name of child or parents insurance is covered under):
Member ID#:_____ Group #: _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S) Front and back

MEDICAL HISTORY AND HEALTH INFORMATION

Current Primary Care Physician (PCP) Name: _____

Address: _____ Phone: _____

Other Healthcare or Medical Provider Names (psychiatrist, pediatrician, etc.):_____

_____

Address: _____ Phone: _____

Current Medications: _____

Over the Counter Medications: _____

Food/Drug Allergies: _____

Physical Exam in the past year? _____ Yes _____No

Consent to Communicate with Primary Care Physician? _____ Yes _____No

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If no, reason for refusal: _____

CURRENT SCHOOL PLACEMENT

Name of School: _____Class: _____
Days and Time of Attendance Weekly: _____
Special Services Provided at School: _____

Past or current history and/or treatment of:
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: _____

Family Members (please check all that apply):

_____ 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, of the following, and if so 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 _____

COMMUNICATION 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
_____Does not try to communicate but caregivers give what is wanted and needed.
_____Tablet (Prologue)
_____Pulls people, points, or stands by what he/she wants.
_____Needs prompting to communicate
_____Other: _____

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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

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.

_____Hyperactivity
_____Impulsivity
_____Tantrums
_____Low frustration tolerance
_____Reduced attention span
_____Sloppy eating habits
_____Interrupts frequently
_____Does not learn from experience
_____Destructive to property
_____Sleep disturbances
_____Reduced attention to danger
_____Accidents (falls, bumps into things)
_____Unusual fears (Please specify):
_____

_____Refusing to follow instructions
_____Verbal Threats
_____Crying/Whinning
_____Screaming Yelling
_____Crying/Whinning
_____Scratching
_____Biting
_____Spitting
_____Kicking
_____Flopping on the floor
_____Running away/bolting
_____Verbal Protesting/refusal
_____Self harm (hitting self)
_____Hurt others

_____Does not learn from experience
_____Head banging
_____Drooling
_____Eating inedible objects
_____Poor memory
_____Hyperactivity
_____Nightmares
_____Staring episodes ("spacing out")
_____Repetitive movements (hand waving, rocking, spinning) Please specify: _____
_____
_____Repeat activities for prolonged periods of time. Please specify:_____

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1950 Keene Rd, Building K, Richland, WA 99352

We now have the ability to email and/or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign.

Consent to Email and/or Text Message for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Child Enrichment Center.

_____ (***Patient initials***) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The **cell phone number** that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is
(_____)_____-_____Carrier:_____

_____ (**Patient initials**) I consent to emails, to receive communications as stated above.

The **email** that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information
is_____.

-I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information

Start Date: _____ End Date: _____ (can indicate up to one year)

Patients Signature: _____Date:_____

CEC Staff Signature: _____ Date:_____

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Consent to Provide Initial Intake Service

Child's name: _____ DOB: _____ Diagnosis: _____

Name and address of Agency to provide services (check box):
☐ **Child Enrichment Center: 1950 Keene Rd. Building K, Richland, WA** 99352
office.childenrichmentcenter@gmail.com Phone: (509) 420-3442 Fax: (858) 521-8173

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 service 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 these 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 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 Child Enrichment Center's Notice of Privacy Practices.

_____ _____
Printed name of Parent/Legal Guardian providing consent Relationship

_____
Signature of Parent/Legal Guardian providing consent Title Date

_____
Signature of admitting staff person Title Date

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Notice of Privacy Practices

This is yours to keep

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 [_____], 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 a number of 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, pre-certification 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.

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

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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 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.
(3) 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.
(4) You have the right to inspect, copy, and request amendments to you 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.
(5) 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.
(6) 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.
(7) 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.

All questions concerning this Notice or requests made pursuant to it should be addressed to PRIVACY OFFICER, 1950 Keene Rd, Building K, Richland, WA 99352.