F.A.I.T.H.

(Furtherance of Autism with Intervention, Treatment, and Health services)

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ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

Client name :
Insurance Company:
Eligibility Dates/Number of sessions:
Co-pay per visit: Cost-share per visit:
Deductible: Other:

****

- I hereby authorize treatment to the above named client by F.A.I.T.H. ABA therapy and Consultation services
- The episode for ABA will begin with the initial treatment on and end upon formal discharge. Estimated length of treatment:
- Cash clients only: I understand that no insurance company is being billed for services rendered. I agree that payments are due on the 30th of each month unless other arrangements have been made. The other arrangements are:

- Contracted providership and /or pre-authorization from any insurance company for services rendered is not a guarantee of payment from that insurance company. Additionally, every insurance company reserves the right to deny coverage. By my signature below, I accept full financial responsibility for any denied services provided to my child, regardless of whether or not my insurance company holds me harmless. I agree to pay no more than the office visit charged for each visit upon request.
- If my insurance status changes, I agree and understand that it is my responsibility to notify F.A.I.T.H. with adequate time to arrange any authorizations necessary to continue billing and collecting for treatment from my new insurance company. I agree to pay for any dates of service that are denied and/or not billable as a result of changes in my insurance status.
- I agree to pay any unpaid portion of my account balance upon request or according to any payment plan agreed on by F.A.I.T.H.. I will pay additional fees, beginning with a charge of no less than 33 1/3 % of my balance, for attorney's fees or any other related costs of collection, should such action become necessary.
- I understand and agree to pay $25.00 in cash or money order, as well as the face value of the effected check, for any returned check. I also agree to make all payments in cash or money order in the future.

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- My signature below is evidence that my signature is on file with F.A.I.T.H. for filing any insurance forms for treatment provided to me, or for any person with who I am financially responsible. The notation, "SIGNATURE ON FILE" shall be treated as if I signed the form personally. I authorize release of any and all medical and/or charge information as necessary to obtain third party reimbursement.

My signature below indicates that I understand and agree to all of the above:

_____	_____
Signature of Guarantor	Printed name of Guarantor
_____	_____
Social Security Number of Guarantor	Date of Signature

F.A.I.T.H. ABA therapy and Consultation, 2444 Commerce Road, Suite #215, Jacksonville, NC 28546
Phone: 615-294-1221
Fax: 910-327-2716
Email: hr@faithisallyouneed.net
Website: www.faithisallyouneed.net

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HEALTH INSURANCE INFORMATION SHEET

Health Policy Holder's Name:

Address:

Phone Number:

Date of Birth:

Policy Holder's Social Security Number:

Policy Holder's Health Insurance Number:

Client Name:

Client Address:

Client Date of Birth:

Client Social Security Number:

Other Health Insurance Yes No

If Yes, name of company:

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AUTHORIZATION FOR RELEASE OF INFORMATION FORM

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Patient Name:
ID Number:
Persons/Organizations providing information: F.A.I.T.H. and _____
(list your insurance provider)
Persons/Organizations receiving information: F.A.I.T.H. and _____
(list your insurance provider)
What is the purpose of the use for disclosure? Claims/progress reports/ authorization requests

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

I understand that this authorization will expire on January 1, _____.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

Signature of patient or patient's representative_____
Date: _____
Printed name of patient's representative:
Relationship to the patient:

You may refuse to sign this authorization.

END OF AUTHORIZATION

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PROVIDER NOTICE
OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SEE ATTACHMENT FOR CLIENT TO KEEP

Acknowledgement of receipt of Notice of Privacy Practices:
Please sign your name, print the name of the minor child of whom you're signing on behalf of, print your name, and date on this acknowledgement form. Then detach the form from the Notice along the line and return your signed acknowledgement to the therapist.

Signature:_____on behalf of (Childs name):

Printed name of person signing:

Date:

Received by:_____

Printed name:

Date:_____

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PHOTO RELEASE

F.A.I.T.H. has permission to use photographs and video of my child for therapeutic purposes and data analysis.

_____

(print name here)

_____

Signature of parent/responsible party Date

F.A.I.T.H. has permission to use photographs and video of my child,

_____

(print name here)

on the company's web-site, in publications that promote F.A.I.T.H., and for display in the office. If at any time, a photograph is needed for a use other than those listed above, F.A.I.T.H. will ask for a separate permission slip.

_____

Signature of parent/responsible party Date

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ATTENDANCE CONTRACT

Client Name:

Please initial each clause as you read it then sign the bottom.

F.A.I.T.H. strives to provide a quality therapy service that assists each child, as a whole, to achieve the highest level of skills possible. We believe therapy is most effective when attendance is at 90% or greater. Timeliness to therapy is equally important. Therefore, it is agreed that (please initial on each line)

_____ Attendance to therapy sessions will be at a rate of 90% or greater for the duration of treatment.

_____ When a session is cancelled at least one day prior to the appointment time, every effort will be made to reschedule that missed appointment so as to keep attendance in good standing.

_____ A "no-show" is an appointment that is missed without a phone call to cancel within 24 hours of the beginning of the appointment time. If you are going to be more than 15 minutes late for your scheduled appointment, regardless of reason, a phone call is required to insure the appointment is not counted as a no-show.

_____ Three no-show appointments result in discharge from therapy.

_____ If you have no phone and you are unable to keep a scheduled appointment, please call us as soon as you are able to get to a phone, even if it's after the scheduled appointment.

_____ If you are leaving for a family trip, vacation, etc, try to give at least a 3 weeks notice.

I have read and agree to the above terms.

_____

Parent/responsible party Date

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Client Case History Form - Child

Form Completed By:

Please check one: ___Spouse ___Parent ___Guardian Date:

Please fill in this questionnaire carefully. It is important to fill in ALL sections.

I. Client Personal Data

Name:	Date of Birth:	Sex:
Address:		
email:		
Mailing address (if different)		

Client lives with:
Referred by:
Reason for referral:
Is child adopted: If yes, at what age? From what country?

Fathers Name:	Date of birth:
Address:	
Home phone:	
Cell phone:	
Email:	
Place of Employment:	Occupation/Rank:
Work Phone:	

Mothers Name:	Date of birth:
Address:	
Home phone:	

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Cell phone:	
Email:	
Place of Employment:	Occupation/Rank:
Work Phone:	

Guardian's Name:	Date of birth:
Address:	
Home phone:	
Cell phone:	
Email:	
Place of Employment:	Occupation/Rank:
Work Phone:	

Siblings:

Name	Sex	Age	Diagnosis

Language spoken in Home:	
Child's school:	City:

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Days per week:	Hours per week:	Grade:
Type of classroom:		
School telephone:		

II. Medical History

Your child's health is: _____Excellent _____Good_____ Fair_____ Poor

Child's Physician:	
Address:	
Child's birth weight:	Length of Pregnancy:
Generally describe pregnancy and delivery:	
Complications during birth:	
Complications after birth:	

DIAGNOSIS:

Diagnosis(dx):	(DSM code)
Diagnosed by:	
Date of Diagnosis:	Age of diagnosis:
If multiple diagnosis, please list:	
Generally describe child's development:	

Has your child been hospitalized:	If yes, why?
Surgeries:	If yes, describe?
Seizures?	If yes, what type?
Frequency of seizures?	Length?

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Currently taking medications?	If yes, please list medications, start date, and for what/why?
Please list all medications previously taken?	
Any known drug allergies?	if yes, please list?
Are there any medical problems which place limitations on physical activities?	
If yes, please list?	

Describe child's diet (poor, overeats, cravings, foods, etc.):	
Food allergies?	If yes, please list?

Does your child have hearing loss?	if yes, to what extent?	
Is child currently seeing a specialist or received services in the past?		
Please list specialist seen:		

Current Specialists seen:

Specialist:		Dates
Telephone number:		
session length:	Days seen:	Frequency:

Specialist:		Dates
Telephone number:		
session length:	Days seen:	Frequency:

Specialist:		Dates
Telephone number:		
session length:	Days seen:	Frequency:

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Has your child received other therapies or other learning assistance? If so, please list:

Other health problems?	
If yes, please list?	

III. **Speech and Language Development**

How old was your child when he/she:

Used speech like sounds:	Spoke first real word:	
Began putting words together:		
How many words were in your child's vocabulary at: Age 1 year: Age 1 1/2 years: Age 2 years:		
How many words are in your child's vocabulary now?		
Did your child have speech that was lost?		
If yes, what age did he/she start to lose speech?		
Was he/she ill at the time of loss?		
What is your child's usual way of communicating?		
Does your child cry to let you know when he/she wants something?		
Does your child say what he/she wants?		
Does your child follow verbal directions without given any visual cues?		

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GOALS AND OBJECTIVES:

Please list some goals that you would like your son or daughter achieve in this program (i.e. eating different kinds of foods or speaking in sentences, playing with siblings more, etc.)

What could be used as reinforcers for your child (i.e. swinging, list favorite foods/snacks, reading favorite books, favorite toys, jumping, spinning, tickles, etc.):

Please list any other favorites (i.e. favorite color, favorite cartoon character, song, etc.):

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F.A.I.T.H. RETURN FORM

I have read the enclosed information and wish to be scheduled for an Initial Consultation/ Therapy services.

Please Check

_____ F.A.I.T.H. Return Checklist
_____ Client Case History
_____ Health Insurance Information Sheet
_____ Assignment of Benefits And Financial Agreement
_____ Payment Reminder Statement Policy
_____ Attendance Contract
_____ Photo Release
_____ Contagious Disease Policy
_____ F.A.I.T.H. Policies
_____ Provider Notice of Privacy Practices

_____

Signature of parent/responsible party Date

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