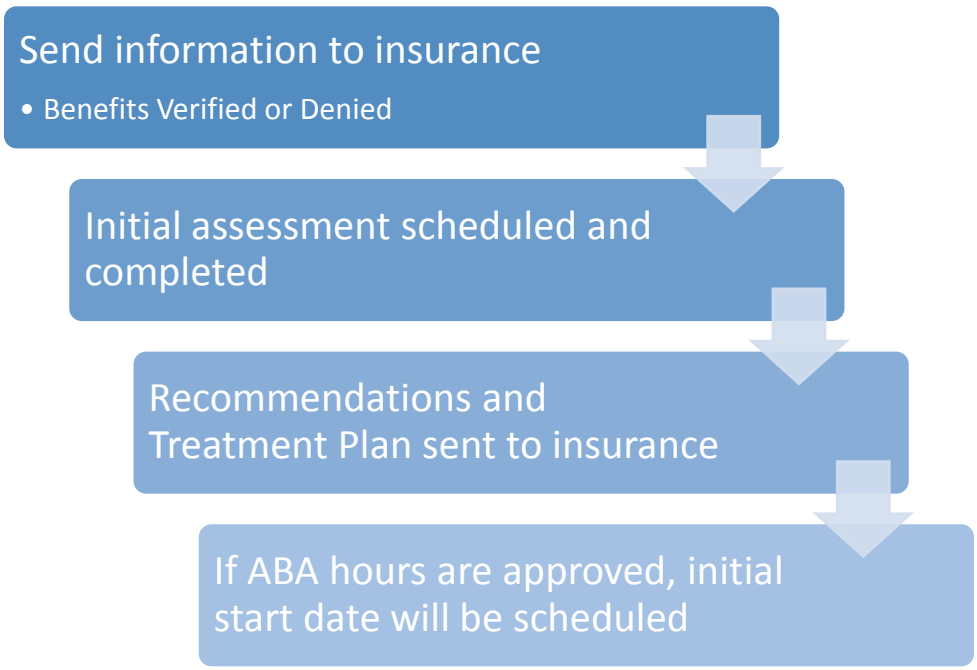
Riverbend

We appreciate your interest in our Outpatient ABA Services. To begin the new client process, please submit the below listed documents:

- ✓ **Insurance Verification form (Provided below)**
- ✓ **Client Intake form (Provided below)**
- ✓ **Front and back copy of all insurance cards for your child**
- ✓ **Diagnostic report from diagnosing physician, diagnosing Autism Spectrum Disorder**

Once these items have been received, our clinical team will complete the following processes:



Please send all information to: Outpatient@Riverbendbh.com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Autism Services Insurance Verification Request

Today's Date:	Requesting Site: Riverbend OP	Rendering Provider:

PATIENT INFORMATION

Child's Name: (first/last)		Parent/Guardian:
Phone Number:		DOB: Gender: M or F
Street Address:		City/State/Zip:
Diagnosis:	Services Requested: ABA	Diagnosing Physician:
Date of Diagnosis:		Diagnosing Physician Contact:
Primary Care Physician:		Primary Care Physician Contact:

INSURANCE INFORMATION

Primary insurance: **__New Insurance __ Old Insurance __Termed Date __ /__/__**

Subscriber's name:	Birth date:	
Subscriber's S.S. no.:	Policy no:	Group No:
Employer:		
Patient's relationship to subscriber:		

Secondary insurance:

Subscriber's name:	Birth date:	
Subscriber's S.S. no.:	Policy no:	Group No:
Employer:		
Patient's relationship to subscriber:		

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

FOR OFFICE USE ONLY

Eligible: ____ Yes ____No		Limitations
Coverage:	Deductible:	DOP Max:
CPT Procedures Eligible for Therapy:		
Ref#;	Insurance Rep:	Pre-Auth Necessary:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Name of Provider** or insurance company to release any information required to process my claims

Patient/Guardian signature	Date

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CLIENT INTAKE FORM BEHAVIORAL INTERVENTION SERVICES

Background Information History

Child's Name: _____

Date of Birth: _____ Current Age: _____ Boy □ Girl □

Father's Name: _____ Occupation: _____

Mother's Name: _____ Occupation: _____

Home Address: _____

Home Phone: _____

Mom Work/Cell: _____

Dad Work/Cell: _____

Email: _____

Siblings: 1. (Name)_____ (Sex)_____ (Age) _____

2. (Name)_____ (Sex)_____ (Age) _____

Diagnosis: _____

Diagnosed by: _____

Date of Diagnosis: _____ Age at Diagnosis: _____

Previous and Current Interventions (Speech Therapy, Occupational Therapy, Behavioral Therapy, other services)

Intervention 1: _____

Provider: _____

Dates of Intervention: _____/_____ to _____/_____ MM/YY MM/YY

Intervention 2: _____

Provider: _____

Dates of Intervention: _____/_____ to _____/_____ MM/YY MM/YY

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Intervention 3: _____

Provider: _____

Dates of Intervention: _____/_____ to _____/_____ MM/YY MM/YY

What community resources are you currently utilizing? (ex: support groups, church respite, etc)

_____

_____

Are there any current or previous legal issues that would affect treatment?

_____

_____

Please list all current medications (including homeopathic, herbal or vitamin-based remedies).

MEDICATION	DOSAGE/FREQUENCY	PRESCRIBED FOR

Developmental History

Describe pregnancy and delivery: _____

_____

Is there a family history of mental or developmental disabilities?

_____

Please list any childhood illness; list the child's age, the illness, and the treatment prescribed.

_____

Is your child hypersensitive to sound or other sensory stimuli? Yes □ No □ If yes, what stimuli?

_____

Self-Help Skills Please describe your child's current level of functioning in the following areas:

Toileting: _____

_____

_____

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Feeding: _____

_____

_____

Dressing: _____

_____

_____

Grooming: _____

_____

_____

Problem Behaviors

Please describe any problematic behavior(s). Examples are: non-compliance, aggression, head banging, tantrum, etc

Behavior #1_____

How often does it occur?_____

What usually triggers this behavior?

_____

_____

What do you do when this behavior occurs?

_____

_____

Behavior #2_____

How often does it occur?_____

What usually triggers this behavior?

_____

_____

What do you do when this behavior occurs?

_____

_____

Behavior #3_____

How often does it occur?_____

What usually triggers this behavior?

_____

_____

What do you do when this behavior occurs?

_____

_____

Behavior #4_____

How often does it occur?_____

What usually triggers this behavior?

_____

_____

What do you do when this behavior occurs?

_____

_____

Self-Stimulatory Behaviors Repetitive mannerisms: (such as hand flapping, finger flicking, gazing, lining up objects, hoarding objects, toe walking, running back and forth, repeating previously heard words out of context, etc.) _____

_____

_____

Difficulty with transitions or changes in routine:

_____

_____

Unusual preoccupations/obsessions: (anything he or she likes to do repeatedly)

_____

_____

_____

Social Behavior

Does your child show you affection? Yes □ No □ How? _____

_____

_____

Does your child play with toys or other items (e.g. computer, video games, sports, etc.)?

Yes □ No □ If so, describe how. _____
_____
_____

Does your child have good eye contact? How often and with whom? _____
_____

Does your child respond to his or her name? Yes □ No □

Does your child come to you for comfort? Yes □ No □

Does your child come to you for attention? Yes □ No □

Does your child respond better to any particular person? To whom? _____
_____

Does your child show interest in other people? How? _____
_____

Language

Please describe briefly, your child's onset and development of language: _____
_____
_____

How does your child communicate? _____
_____

Does your child follow verbal directions when not given any visual cues? Yes □ No □

Does your child say words/phrases/sentences? If yes, give examples. _____
_____
_____

Educational Background

Does your child attend school? Yes □ No □

Name of School: _____

Address: _____

Grade_____

How long has your child been attending school? _____

What accommodations does your child receive at school? _____

Do they have an IEP? If so, when was the most recent IEP Meeting? _____

Spiritual

Respecting your individual family beliefs is important to the staff at Riverbend. The following questions are voluntary and are not required to be considered for services.

What type of spiritual religious support would you like to have while engaged in services with our facility?

_____

Do you believe in God or a Higher Power? _____Yes _____No

Do you practice meditation? _____ Yes _____ No

Do you have a formal church support group you would like us to be aware of? _____ Yes _____No

(name of church support group) _____

Goals and Objectives Please list several goals that you would like your son or daughter to achieve by participating in behavioral intervention services (e.g., eating a wider variety of foods, using words to make needs known, speaking in sentences, playing appropriately with toys, developing and/or maintaining friendships, etc.)

_____
_____
_____
_____

Parent Name _____
Parent Signature _____
Date _____

Please email, mail or fax information to:

Riverbend ABA Outpatient Center
701 N Niles Ave
South Bend, IN. 46617
Outpatient@Riverbendbh.com
Fax: 1-800-719-3181