INTAKE PACKET

Please fill out this packet as completely as possible. This information will assist in the evaluation process. Please bring the completed packet with you the day of the initial evaluation.

NOTE: ALL INFORMATION PROVIDED IS KEPT CONFIDENTIAL

Person completing the Intake Packet: _____

Relation to patient: _____

Patient Information:

Child's Name: _____ DOB: _____

Nickname / Goes by: _____

Address: _____

Home Phone: (____) _____ Alternate Phone: (____) _____

Responsible Party Information:

Guarantor's Name: _____ DOB: _____

Social Security #: _____ Relation to patient: _____

Address if different than patient: _____

Home Phone: (____) _____ Alternate Phone: (____) _____

Employer: _____ Phone: (____) _____

Email Address: _____

Emergency Contact Information:

Name: _____ Relation: _____

Address: _____

Home Phone: (____) _____ Alternate Phone: (____) _____

Insurance Information:

Primary Insurance Name: _____

Policy ID #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____

Relation to patient: _____

Secondary Insurance Name: _____

Policy ID #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____

Relation to patient: _____

Family History:

Father's Name: _____ DOB: _____

Place of Employment: _____ Phone: (____) _____

Occupation: _____ Highest Grade Completed: _____

Mother's Name: _____ DOB: _____

Place of Employment: _____ Phone: (____) _____

Occupation: _____ Highest Grade Completed: _____

If parents do not live together, describe custody arrangements: _____

Child is our: Biological ☐ Adopted ☐ Foster Child ☐

Siblings:

Name	Age	M / F	Speech, Hearing, or Medical Conditions

Rev 9.3.20

Pregnancy / Birth History:

Did mother have any of the following during the pregnancy?

Bleeding	☐	Virus Infection	☐	Accident	☐
Swelling	☐	Rubella	☐	Surgeries	☐
High Blood Pressure	☐	Diabetes	☐	Smoking	☐
Low Blood Pressure	☐	Asthma	☐	Toxemia	☐
Heart Condition	☐	Convulsions	☐	X-Ray	☐
RH Negative	☐	Anesthesia	☐		
Kidney Disease	☐	Excessive Weight Gain/Loss	☐		
Alcohol Consumption	☐	Thyroid Condition	☐		

If yes, provide additional information: Which week/month of gestation? Was hospitalization necessary? _____

_____

Did mother take any medications during the pregnancy? If yes, which medications? _____

_____

What was the length of the pregnancy? _____

What was the length of hard labor? _____

Type of delivery (circle one):

☐ vertex (head presentation) ☐ breech ☐ cesarean ☐ dry ☐ other

Were there any unusual problems at birth? _____ If so, describe: _____

_____

Birth Weight: _____ Apgar score at 1 minute: _____ at 5 minutes: _____

Were there any health problems during the first two weeks of infant life?

Jaundice	☐	Transfusions	☐	Hemorrhage	☐
Blueness	☐	Feeding Difficulty	☐	Tube Fed	☐
Breathing Difficulty	☐	Oxygen	☐	Convulsions	☐
Incubator or Isolate	☐	For how long	_____		

Was the first cry: strong ☐ weak ☐ high ☐

Were intravenous or intramuscular fluids required? _____

How long did the child remain in the hospital? _____ Mother? _____

Is there any additional information regarding mother or baby during pregnancy and delivery that would help us to evaluate the child? _____

_____

Medical History:

Has the child have any of the following illnesses, surgeries, or injuries? If yes, please note at what age and the severity.

Whooping cough _____ Ear Infections _____

Mumps _____ Draining Ears _____

Scarlet Fever _____ PE Tubes Inserted _____

Measles_____ Tonsillectomy _____

Chicken Pox _____ Adenoidectomy _____

Pneumonia _____ Allergies _____

Diphtheria _____ Epilepsy _____

Croup _____ Encephalitis _____

Influenza _____ Typhoid _____

Headaches _____ Tonsillitis _____

Sinus problems _____ Chronic Colds _____

Meningitis _____ Head Injury _____

Rickets _____ Mastoidectomy _____

Rheumatic Fever _____ Asthma _____

Polio _____ Dental problems _____

Please describe any other operations or medical conditions your child has had that are not listed above: _____

_____

Pediatrician Name: _____ Office Phone: (____) _____

List all doctors the child sees routinely:

_____

List all current medications your child is currently taking, both prescription and over the counter:

_____

Does your child have any seizure conditions? _____ Under what conditions? _____

_____

Is there any additional medical information that you feel would help with evaluating the child? ____

_____

Developmental History:

Has your child ever had ABA, speech/language, or occupational therapy in the past? YES

If so, what type of therapy and when? _____

Where was therapy received?_____

Reason(s) for therapy: _____ Goals achieved? YES

What is the primary language spoken in the home? _____

Are there any additional languages spoken in the home?_____

At what age did your child say his/her first word? _____

At what age did he/she use 2-word phrases? _____

At what age did he/she use sentences? _____

Has speech/language ever seemed to stop or decrease for a period of time? _____

If so, please describe: _____

How well can the child be understood by immediate family?_____

How well can the child be understood by others? _____

Which ONE does your child use most often? (circle one)

☐ Sentences ☐ Phrases ☐ One or two words ☐ Sounds ☐ Gestures

Do you question your child's ability to understand directions and/or conversations? _____

If so, why?_____

Does your child hesitate, "get stuck", repeat, or stutter on sounds or words?_____

If so, describe: _____

MY MEDICATION LIST

Patient Name: _____ **Date of birth:** _____

List all medicine you are currently taking: Prescription and over-the–counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include medications taken as needed (examples: inhalers, nitroglycerin).

Medication (Brand and Generic Name)	**Dose**	**How and How Often You Take the Medication**	**Reason for taking**	**Date Started**	**Prescriber**

Can your child read? _____ At what age did he/she begin reading? _____

Does your child's voice sound hoarse? _____ Low-Pitched? _____ Nasal? _____

Do you think your child hears adequately? _____

Do you think his/her hearing ability varies from day to day? _____

Has your child's hearing been checked recently? _____ What were the results? _____

_____

Note the ages that the following occurred:

Hold head erect	_____	Crawl	_____
Follow object with eyes	_____	Feed self with spoon	_____
Roll from back to stomach	_____	Sit unsupported	_____
Reach for objects	_____	Stand alone	_____
Dress self	_____	Walk alone	_____
Toilet trained	_____		

Is there any additional developmental information that you feel would help with evaluating the child? _____

_____

School Age History:

Preschool: _____ Age level/Teacher: _____

School: _____ Grade/Teacher: _____

Describe your child's typical grades / reports from the school: _____

_____

What concerns do you or the school have regarding school performance? _____

_____

Regarding attention/concentration? _____

Regarding work habits? _____

Regarding behavior? _____

Does your child receive special education services at school? YES

What services are received? _____

Does your child have an IEP? YES What is the date of the last IEP? _____

Is there any additional school related information that you feel would help with evaluating the child? _____

_____

Associated Services:

Intelligence testing: YES Date: _____ Where: _____

Results: _____

Neurologic testing: YES Date: _____ Where: _____

Results: _____

Psychological testing: YES Date: _____ Where: _____

Results: _____

Physical Therapy evaluation: YES Date: _____

Where: _____

Results: _____

Occupational Therapy evaluation: YES Date: _____

Where: _____

Results: _____

Speech/Language Therapy evaluation: YES Date: _____

Where:

_____

Results: _____

Please provide copies of any evaluation reports to Red River Therapeutic Solutions*

Additional Background Information:

Describe your main concerns: _____

_____

_____

_____

When were concerns first noticed? _____ By whom? _____

What changes in your child's development and/or behavior have you noticed since that time? _____

List the people / organizations that you have consulted about the concerns:

Date	Name / Address	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferences:

Please indicate anything that the clinicians should know when working with him/her: _____

- Preferences (favorite activities, food, interests/topics, sensory) _____
- Dislikes (aversions) _____
- Other _____

AREAS OF CONCERN

- ☐ Difficulty swallowing
- ☐ Mouthing objects inappropriately
- ☐ Excessive drooling
- ☐ Biting, pinching, etc.
- ☐ Uses only 1-2 words
- ☐ Refusal to obey
- ☐ Echolalia
- ☐ Stuttering
- ☐ Poor sentence structure
- ☐ Difficulty answering questions
- ☐ Numerous ear infections
- ☐ Misarticulating of words
- ☐ Seizure activity
- ☐ Impulsiveness
- ☐ Difficulty with change
- ☐ Dislikes being touched
- ☐ Places self in dangerous situations
- ☐ Clumsy, trips often
- ☐ Weakness in arms, legs, trunk
- ☐ Poor balance
- ☐ Unable to catch tossed ball
- ☐ Toe-walks
- ☐ Spins inappropriately
- ☐ Poor handwriting
- ☐ Poor hygiene
- ☐ Uses one hand more than other hand
- ☐ Difficulty chewing food
- ☐ Picky eater
- ☐ Inappropriate toy play
- ☐ Does not understand simple directions
- ☐ Difficulty sleeping
- ☐ Runs from parents, teachers, etc.
- ☐ Distractibility
- ☐ Poor/inappropriate eye contact
- ☐ Pronoun misuse
- ☐ Poor social interaction
- ☐ Delay in sitting up
- ☐ No verbal language
- ☐ Bedwetting
- ☐ Thumb sucking
- ☐ Fixates on television/videos
- ☐ Dislikes malls, shopping centers, etc.
- ☐ Delay in pulling up, crawling
- ☐ Poor eye-hand coordination
- ☐ Unable to ride bicycle
- ☐ Fear of swings, playground equipment
- ☐ Increased muscle tone in arms, legs
- ☐ Lines up objects
- ☐ Weak hand muscles
- ☐ Unable to dress/undress self
- ☐ Unable to skip or hop on one foot
- ☐ Cannot feed self independently

AREAS OF CONCERN

- ☐ Strong gag reflex
- ☐ Difficulty climbing stairs
- ☐ Uncoordinated running pattern
- ☐ Intolerant to textures
- ☐ Hums to self
- ☐ Stimming activity / hand flapping

Please provide any additional concerns or information that you feel may be important regarding your child:

_____

_____

_____

_____

_____

_____

Please list your child's strengths:

_____

_____

_____

Please describe below important cultural practices, rituals, traditions or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship:

_____

_____

_____

Printed name of person completing form: _____

Signature of person completing form: _____

Date Completed: _____

ALLERGY NOTIFICAITON

From time to time your child's therapist may utilize examination gloves and various foods in the course of therapy to assess or stimulate certain speech-related behaviors. We are aware of the fact that some children are allergic to the materials used in examination gloves and may be on specialized diets or have food allergies. Please read the following lists carefully and indicate any allergies you know your child has. Please list any other known allergies in the space below. This information will be noted in a prominent place on your child's chart. Please keep your child's therapist informed of any allergic reaction, which are identified in your child over the course of his/her therapy program. Your child's health and safety are of the utmost importance to us.

The following are some of the foods and substances commonly used in therapy. Please circle any that your child is allergic to OR any which are not a part of your child's special diet:

- ☐ Talc (powder)
- ☐ Sour Straws/Sour Patch Kids
- ☐ Popcorn
- ☐ Veggie Straws
- ☐ Fruit Snacks
- ☐ Juice
- ☐ latex
- ☐ Chips (Lays, Doritos, Fritos)
- ☐ Chocolate M&M's
- ☐ Assorted Goldfish
- ☐ Skittles
- ☐ Dried cereal (Cheerios, Fruit loops)

Please list ANY other known allergies: _____

_____

If your child has no known allergies, please write "NO KNOWN ALLERGIES" in the blank below before signing this form:

_____

I have provided the information above to the best of my knowledge at the request of Red River Therapeutic Solutions, LLC. and my child's therapist of any change in the status of the above information.

Child's Name: _____

Responsible Party: _____

Today's Date: _____

AUTHORIZED PERSON(S)

Child's Name: _____ DOB: _____

As the parent/guardian of the child listed above, I hereby authorize the Representatives at Red River Therapeutic Solutions, LLC. to discuss any information regarding therapy sessions, progress, treatment plans and scheduling of my child with the following person(s). I hereby further authorize the following person(s) to pick up my child from his/her scheduled appointments with Red River Therapeutic Solutions, LLC.

AUTHORIZED PERSON(S)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

AUTHORIZATION TO BILL INSURANCE

Client Name: _____ DOB: _____

I, _____, hereby give my consent for Red River Therapeutic Solutions, LLC to bill my/my child's insurance plan for the services rendered to my child by the above- mentioned provider. In addition, I agree to pay Red River Therapeutic Solutions, LLC any deductible or uncovered charge in accordance with my health care plan.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INSURANCE PLAN

I understand that my express consent is required to release any health care information relating to assessment and treatment. I, _____, hereby give my consent for Red River Therapeutic Solutions, LLC to release medical and other relevant information to our insurance plan as required by my/our insurance plan to process medical billings.

_____ _____

RESPONSIBLE PARTY SIGNATURE D.O.B.

_____ _____

RESPONSIBLE PARTY PRINTED NAME DATE

Informed Consent

Client Name: _____ DOB: _____

I, _____, agree to have my child _____ evaluated/treated through Red River Therapeutic Solutions, LLC. I understand that these services are based on an applied behavior analysis (ABA) model and will be provided by a professional trained in ABA. I understand that state laws may require that confidentiality be broken under certain circumstances, specifically, if I am perceived by the behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected child abuse.

I also understand that Red River Therapeutic Solutions, LLC specializes in the evaluation and treatment of problem behaviors as well as skill acquisition, and if Red River Therapeutic Solutions, LLC is unable to meet my particular needs, I will be referred to an appropriate agency or individual.

Services: Red River Therapeutic Solutions, LLC implements the Applied Behavior Analysis for its services. A variety of techniques are integrated and utilized during treatment. You will be encouraged to practice various skills introduced in sessions. A treatment plan with specific goals will be explored and updated according to treatment plan schedules. Recommendations for additional treatment and/or intensive treatment may be made, if needed. Information will be limited to accommodate confidentiality with children of all ages. Family involvement is an important part of treatment. Children under the age of 18 will require a parent's signature (or legal guardian) to receive any form of treatment.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

CONSENT FOR SECURE/RELEASE OF INFORMATION

Child's Name: _____ Date of Birth: _____

Address:

_____

I/WE hereby authorize and request Red River Therapeutic Solutions, LLC. to secure and /or release medical, social, educational, and other clinical information regarding the patient named above. I/WE understand that this authorization maybe revoked in writing at any time. Otherwise this consent automatically expires two years from the date of signature. This authorization applies only to the following individuals/institutions: If not completed, no information will be released from our office.

Primary Care Physician: _____

Address: _____

Other: _____

Address: _____

I/We give permission for the therapist and or staff at Red River Therapeutic Solutions, LLC to disclose/ request information regarding scheduling of school based appointments, therapy, school performance, and/or any information deemed relevant to academic and therapy success. Information will not be disclosed to anyone not specifically listed below.

School Name: _____

Address: _____

Other: _____

Address: _____

I/We give permission for Red River Therapeutic Solutions to communicate via email, information, i.e. evaluations, therapy updates, and/or other clinical information regarding the patient listed above. Information will not be disclosed to anyone not specifically listed below.

Email Address: _____

Email Address: _____

I hereby further direct that a copy of this authorization shall be deemed to be as valid as the original for all purposes authorized herein.

Signature: _____ Date: _____

Relationship (if person named above is a minor): _____

Witness signature: _____

PARENT HANDBOOK ACKNOWLEDGEMENT

Child's Name: _____ DOB: _____

I have received a copy of Red River Therapeutic Solutions' Parent Handbook. I have read or explained all of the guidelines listed in the handbook. I agree that I understand all guidelines and criteria for the ABA Services. It **DOES NOT** indicate that I have waived any rights. I acknowledge that at any point during treatment I may withdraw consent to render services, though if you have any concerns at any point you may bring them up to your therapist. I understand that no specific promises, as to the outcome of treatment have been made. Red River Therapeutic Solutions, LLC. also has the right to refer out during any point they believe valid, while providing a 2 week notice of reaching such a decision.

I have received a copy of Notice of Privacy Practices; as well as, Patient Rights and Responsibilities.

Signature of Parent/Guardian: _____

Printed Name of Parent/Guardian: _____

Date Signed: _____

Signature of Clinical Staff: _____

Printed Name of Clinical Staff: _____

Date Signed: _____

PARENT INVOLVEMENT POLICY

This handout will outline our parent involvement standards and give you an opportunity to set goals with us.

Staff Responsibilities:

The role of our therapists is to guide, oversee, and design programs, or to implement programs as part of an individualized ABA therapy program.

- The Board Certified Behavior Analyst® (BCBA®) is a graduate-level certification in behavior analysis. Professionals certified at the BCBA level are independent practitioners who provide behavior-analytic services. BCBAs supervise the work of Board Certified Assistant Behavior Analysts® (BCaBAs®), Registered Behavior Technicians® (RBTs®), and other professionals who implement behavior-analytic interventions. BCBAs are responsible for conducting the initial assessment, creating individualized treatment programs, and supervision of staff in order to monitor your child's progress during ABA Therapy. You will be provided with educational opportunities in the form of handouts or a meeting with your BCBA, depending on the topic.

- The Registered Behavior Technician® (RBT®) is a paraprofessional certification in behavior analysis. RBTs are responsible for implementing behavior change programs outlined by the BCBA. They are also responsible for daily upkeep of patient data collection and debriefing the parents at the end of the day. RBTs typically answer general questions about programs and behavior change interventions.

All ABA Therapists must abide by the *Professional and Ethical Compliance Code for Behavior Analysts.* A copy of this document can be given upon request.

Parent and Guardian Responsibilities:

Parents and guardians are expected to be an integral part of the overall treatment plan. When parents are active participants in their child's treatment, the child is more likely to be successful. Intervention procedures are more likely to be generalized across settings and people, and the child is likely to learn and use skills more quickly.

As the parent, you can provide insights into their environment, daily routines, abilities, and struggles. You have the unique insight to offer information that will help our BCBA(s) create more individualized programming.

I have the following goals for my child during the time they are engaged in ABA therapy:

1. _____

2. _____

3. _____

I have the following goals for myself:

1. _____

2. _____

3. _____

I understand that active parental involvement is necessary and critical to the success of my child's ABA therapy. I will be held responsible for the goals I have listed on this document. I understand that I can meet with the BCBA and modify these goals as needed.

Consistent and excessive instances of lack of active parental involvement on my part may result in a termination of the supervision contract, and a cessation of this working relationship. Lack of active parental involvement can include but is not limited to:

- Failure to maintain adequate communication, respond to requests for information, and submit required data in a timely manner
- Failure to participate in recommended and applicable parent training and parent education as necessary for the success of the ABA program
- Failure to be present for the recommended therapy schedule set by the BCBA
- Failure to follow recommend treatment plans, skill acquisition programs, or behavior reduction plans as written and advised by the BCBA

When it comes to your child, you are the expert. By working together, ABA provides your child with a support team who has the same goals and objectives: helping your child succeed and become the best possible version of themselves.

I have read this handout and understand what is expected of me while my child is receiving ABA Therapy from Red River Therapeutic Solutions, LLC.

Signature of Parent or Guardian	Date Signed
Signature of BCBA	Date Signed

CHILD DROP OFF AND PICK UP AUTHORIZATION FORM

Child's Name: _____

Parent/Guardian Name: _____

Red River Therapeutic Services will not release a child to an unauthorized individual. All individuals who may pick up your child must be listed on this participant pick-up/drop-off authorization form. If any changes need to be made to the authorized individuals, please provide us with an updated list immediately. All individuals who are authorized to pick up your child will be required to produce a state-issued photo identification. If an individual is listed on the pick-up authorization form, you are giving consent for our therapists to provide a summary of your child's day to that individual.

The following adults are authorized to drop-off AND pick-up your child from ABA Therapy. If the adult listed is only authorized to pick-up OR drop-off, please write this out next to their name.

Printed Name: _____

Cell Phone: _____

Relationship to Child: _____

Printed Name: _____

Cell Phone: _____

Relationship to Child: _____

Printed Name: _____

Cell Phone: _____

Relationship to Child: _____

Parent Signature: _____ Date: _____

Patient Label if Applicable

Consent To Obtain, Release And/or Share Information
Medical Records

Name: _____ **Phone:** _____

Address: _____

SSN: _____ **DOB:** _____

This is a request to have my protected health information **X released to** or **X obtained from** a third party. Specifically, I am requesting that the agency listed below forward the indicated information.

Agency Name: _____ **Address:** _____
Phone: _____ **Fax:** _____

X Discharge Summary
X History and Physical Exam
X Psychiatric Evaluation
X Medication History
X Social History
__ H.I.V. Information
X Drug and Alcohol Information
X Other Information: **All Pertinent Information for Treatment**

Purpose of Disclosure: **Release of Medical History for Coordination of Care**

Please mail or fax the requested medical records to:

Name: _____
Address: _____
Phone: _____ **FAX:** _____

I understand that the information released is for professional purposes only and may not be provided in whole or part to any other agency or person other that the one listed above. This consent may be revoked in writing at any time, except when action has already been taken. Under those circumstances, the consent will expire upon completion of the transaction. This authorization expires 365 days from the date of signature unless otherwise stated.

Federal law prohibits the receiving party of this confidential information to further disclose without the consent of the Recipient or parent/ guardian to whom it pertains.

Please understand that failure to sign and authorize for release of information for purposes other than treatment, payment, or operations will not impact health care provided. I acknowledge and give consent for this information to be released via facsimile transmission or mail.

_____ _____
Recipient's Signature Date

_____ _____
Parent/Guardian's Signature Date

_____ _____
Staff Witness Signature Date

Patient Label if Applicable

Consent To Obtain, Release And/or Share Information
Educational Information and Access to Student

Name: _____ **Phone:** _____

Address: _____

SSN: _____ **DOB:** _____

This is a request to have my protected health information **X released to** or **X obtained from** a third party. Specifically, I am requesting that the agency listed below forward the indicated information.

Agency Name: _____ **Address:** _____
Phone: _____ **Fax:** _____

X Attendance	X Individual Educational Plan(IEP)	X Psychological Testing Results
X Social History	X Special Educating Info (504)	X Standardized Testing Results
X Discharge Summary	X Medication History	X Psychiatric Evaluation
X Quarterly Reports	X Schedule of Classes	X Other Information: **All Pertinent Information for Treatment**

Purpose of Disclosure: **Release of Education Records for Coordination of Care**

Please mail or fax the requested medical records to:

Name: _____
Address: _____
Phone: _____ **FAX:** _____

I understand that the information released is for professional purposes only and may not be provided in whole or part to any other agency or person other that the one listed above. This consent may be revoked in writing at any time, except when action has already been taken. Under those circumstances, the consent will expire upon completion of the transaction. This authorization expires 365 days from the date of signature unless otherwise stated.

Federal law prohibits the receiving party of this confidential information to further disclose without the consent of the Recipient or parent/ guardian to whom it pertains.

Please understand that failure to sign and authorize for release of information for purposes other than treatment, payment, or operations will not impact health care provided. I acknowledge and give consent for this information to be released via facsimile transmission or mail.

_____ _____
Recipient's Signature Date

_____ _____
Parent/Guardian's Signature Date

_____ _____
Staff Witness Signature Date

ABA Therapy Arrival /Departure Policy Expectations

Arrival: All full-time clients must arrive at the center at 8:00am each day. On time arrival will ensure that your child is accessing all of their allocated treatment time and allow time for parents to communicate important information to our therapists. Our therapists are not available to start sessions early or provide supervision outside of scheduled times. If you arrive early with your child, please wait outside in your vehicle.

Departure: **Caregivers should arrive at the center 10 minutes prior to the end of your child's day, at 3:50pm each day.** During this time, a clinician familiar with your child's case will provide caregivers with a summary of the child's day.

Red River Therapeutic Solutions, LLC. will not release a child to an unauthorized individual. All individuals pick up your child must be listed on the participant pick up authorization form. If any changes need to be made to the authorized individuals, please provide us with an updated list immediately. All individuals who are authorized to pick up your child will be required to produce a state-issued photo identification. If an individual is listed on the pick-up authorization form, you are giving consent for our therapists to provide a summary of your child's day to that individual. A blank copy of the participant pick-up authorization can be provided upon request.

Excused tardiness: Arrival or pick-up from a session within 5 minutes of the scheduled start time or end time that may occur due to weather or unexpected circumstances, with notification to the center. Caregivers should contact the center if they will be more than 5 minutes late for arrival or pick-up.

Unexcused tardiness: Arrival or pick-up from a session that is more than 5 minutes after the scheduled start time or end time with no contact to Red River Therapeutic Solutions.

Please note that this is considered a probationary period for excessive tardiness after a verbal warning has been provided. Moving forward, after two excessive tardies (dropping off or picking up) within a 2-week period, services will be suspended for one week. After services resume, if additional tardies or cancellation policy issues occur, your case will be reviewed by Red River Therapeutic Solutions to determine the appropriate next steps.

If scheduling prevents your child from being available for the prescribed treatment hours, services may be suspended until they are available. If your schedule will be changing, we ask that you provide an updated availability form as soon as possible, with a minimum 30 days of the change in availability whenever possible. Blank availability forms can be provided upon request.

Parent Signature: _____ Date: _____

ABA Therapy Attendance Policy

Consistent attendance in ABA Therapy is crucial to your child's success. ABA therapy can be a highly effective treatment approach in assisting individuals with autism to make meaningful changes in many areas. However, it is important to understand that changes do not typically occur quickly. Rather, most children require ongoing instruction that builds on their step-by-step progress.

Cancellations: If you are unsure if you can make it to a session for the assigned time (e.g., conflict doctors' appointments), that session will be cancelled. It is important that you attempt to schedule a make-up session with our admin team in order to reach your prescribed treatment hours.

We require that clients attend an average of 85% of all scheduled hours. If attendance begins to fall under 85% of scheduled hours for 2 consecutive weeks, we will notify you. If attendance continues to be under 85% a third week (in a 2-month span) we will schedule a meeting to discuss the issues surrounding the absences.

If scheduling prevents your child from being available for the prescribed treatment hours, services may be suspended until they are available. If your schedule will be changing, we ask that you provide an updated availability form as soon as possible, with a minimum of 30 days prior to the change in availability whenever possible. Blank availability forms can be provided upon request.

I understand that my child's therapy hours are from _____ to _____, on

_____

Child's Name: _____

Parent Signature: _____ Date: _____