Welcome to Eclipse Therapy

Dear Family,

Starting therapy for your child can be exciting as well as overwhelming. We will work together to achieve the goals you set for your child. Included in this packet are a significant number of forms. Please feel free to ask me any question you have via email or phone.

I am excited to embark on this journey with your family.

Sincerely,
Rosalie

An Overview of Eclipse Therapy LLC's Approach

Mission:

To ensure that every family has the opportunity to enjoy the simple pleasures of life: a peaceful family dinner, a quiet game of cards, a movie night out, or an event-free trip to the grocery store. Eclipse will provide consistent and exceptional behavior analytic services to children with disabilities. Services are provided to optimize the child's progress towards their individualized goal.

Purpose:

The cornerstone of Eclipse Therapy is the understanding that any impairment or disability can have a debilitating effect on an individual and the family. With steadfast loyalty, Eclipse will strive tenaciously to increase the child's abilities in an effort to improve the functioning of the child and furthermore increase harmony within the family.

Our approach to working with each child:

- Is individually tailored to meet each child's unique needs
- Is optimized to ensure your child is gaining skills as quickly as possible
- Is based on the most current research

Our programing for autism addresses the major issues common in autism:

- Understanding and using language
- Building broader social skills
- Communicating with and relating to peers
- Building age appropriate and symbolic and play skills
- Building emotional regulation skills
- Increasing flexibility and reducing rigidity
- Increasing conceptual thinking and cognitive skills

Our programing for children with other disorders is individual tailored but will include these essential skills:

- Building emotional regulation skills
- Increasing distress tolerance
- Increasing communicative abilities
- Increasing conceptual thinking and cognitive skills

Eclipse Therapy's trained therapists work one-on-one with each child closely monitoring responses in order to match the difficulty of the material and method of instruction to the child's ability level and rate of learning. All our therapists hold at least a bachelors degree, have extensive training specifically in research

supported treatments for autism spectrum disorders, behavior disorders, and the principals of Applied Behavior Analysis. Supervision of each child's program is provided by one of our BCBA with regular progress reviews monthly.

In addition to the individual ABA program, parent training, programs to address problem behaviors, and a range of behavior analytic services are offered through out our session. Our focus is on helping your child gain skills that are critical to your family and their functioning.

We provide behavioral assessments, parent & staff training, program supervision, and quality in home/school ABA programing. Each of our program supervisors is board certified by the Behavior Analysis Certification Board.

Please call 720-339-1309 for further information or clarification.

Instructions for this packet of information

This packet is rather lengthy, but it will help the Eclipse team better understand you child and the skills they need to acquire or maladaptive behaviors we need to help reduce. Please be as detailed as you can. If something does not apply to your child please write NA.

You can fill out this packet using a PDF filler or print and hand write.

Pages 4-11 and 36 in this document require your signature. Signatures on these pages are necessary to begin treatment

Please return this packet either by email, postal mail, or hand deliver to your child's supervisor. These documents must be submitted before treatment can begin.

We look forward to working with your family! Please do not hesitate to call or email with any questions or concerns.

Consent to Treat

I, the undersigned parent, person having legal custody or guardianship/authorized care provider of _____ (the "minor"), do hereby authorize Rosalie Byrd Prendergast, MS BCBA, of Eclipse Therapy and any of the below Eclipse team members, LLC to provide and/or supervise behavioral health services. Such services may include, but are not limited to Behavioral Assessment, Behavioral Treatment, and Counseling Services. I understand this authorization may be revoked in writing at any time.

_____
Signature of Parent/Guardian/Authorized Care Provider/Client

_____
Date

Eugenia Logvinova, Med BCBA
Katherine Thomas, MS BCBA
Amanda Montoya, MS BCBA
Timothy Mullins, MFTC
Britney Bonner, MFTC
Damian Young, LMFT
Kristy O'Brien, BCABA

Mandatory disclosure for each clinician available upon request. If for any reason you need to file a complaint or grievance below is information to do so. At Eclipse we value your partnership and hope that you will come to us with any concerns that a raise and provide us an opportunity to solve the problem.

a. The Colorado Department of Regularly Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologist, and unlicensed individuals who practice psychotherapy. The agency within Office of Licensing Unlicensed Psychotherapist 1560 Broadway, Suite 1350 Denver, CO 80202, (800) 811-7648.
b. Many of us are also regulated by the Behavior Analyst Certification Board. They can be reached at Behavior Analyst Certification Board 2888 Remington Green Lane, Suite C Tallahassee, FL 32308 850-765-0905

Mandatory Disclosure Statement

1. Name of Therapists:

Rosalie Byrd Prendergast, MS BCBA
Eugenia Logvinova, Med BCBA
Katherine Thomas, MS BCBA
Amanda Montoya, MS BCBA
Timothy Mullins, MFTC
Britney Bonner, MFTC
Damian Young, LMFT
Kristy O'Brien, BCABA

2. Degrees: Rosalie Prendergast, MS BCBA:

BA, University of Northern Colorado, 2004
MS, Nova Southeastern University, 2009
Board Certified Behavior Analyst, 2009
Unregistered Psychotherapist #12185, 2010

3. Agencies I report to:

c. The Colorado Department of Regularly Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologist, and unlicensed individuals who practice psychotherapy. The agency within Office of Licensing Unlicensed Psychotherapist 1560 Broadway, Suite 1350 Denver, CO 80202, (800) 811-7648.

d. Many of us are also regulated by the Behavior Analyst Certification Board. They can be reached at Behavior Analyst Certification Board 2888 Remington Green Lane, Suite C Tallahassee, FL 32308 850-765-0905

4. Client Rights and Important Information:

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Board of Psychologist Examiners.

d. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

e. There are **exceptions** to the general rule of legal confidentiality. Some of these exceptions are listed in the Colorado statutes (see section 12-43-218, C.R.S, in particular). For example, I am required by law to report child abuse. There are other exceptions that I will attempt to identify to you, if feasible at the time, as situations arise during therapy.

_____	_____	_____
Client Name	**Client/Parent/Guardian Signature**	**Date**

Non-Discrimination Policy Statement

It is the policy of Eclipse Therapy to provide services to all persons without regard to race, color, national origin, religion, sex, age, or disability. No person shall be excluded from participation in, or be denied benefits of, and service; or be subjected to discrimination because of race, color, national origin, religion, sex, age, or disability.

Complaint of discrimination policy and procedure: this policy statement complies with Civil Rights Act, Title VI (45CFR part 80.7 B) and section 504 of the Rehabilitation Act of 1973 (45 CFR part 84.7 b. If you feel that you have been denied a benefit or service because of your race, color, national origin, age, sex, disability, or religion you may file a Complaint of Discrimination with the facility administrator of Eclipse Therapy, either verbally or in writing. A written response will be issued to you within 21 days of the complaint notice.

You may also file a complaint with an external agency. If you choose to file your complaint in writing, you must include your name, address, telephone number, and a brief description of what occurred which led you to believe you were discriminated against. If you need assistance, the facility administrator of Eclipse therapy will be able to assist you

You may also file a complaint of discrimination by calling or writing the Department of Regulatory Agencies (DORA) Division of Civil Rights at (303)894-2997 or 1560 Broadway #1050, Denver, CO 80202

Please sign in receipt of this policy.

_____
Patient Name

_____
Signature of Client/Parent/Guardian

Eclipse Therapy LLC
2091 Kerr Gulch Rd
Evergreen, CO 80439
720-339-1309

AUTHORIZATION TO RELEASE INFORMATION

Student/Consumer Name **DOB:**

Street Address: **City/State** **ZIP**

I understand this release is voluntary and applies to all programs and services operated under the auspices of Eclipse Therapy LLC. I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. **I understand that I may revoke this authorization at any time by notifying Eclipse Therapy LLC in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.**

I hereby authorize Eclipse Therapy LLC to (check all that apply):
❒ Exchange with ❒ Release to ❒ Obtain from **the parties I have indicated below**

I hereby authorize Eclipse Therapy LLC to exchange / release / obtain information:
❒ Verbally only ❒ In written form only ❒ Both verbally and in writing

Organization or Individual receiving/communicating the information:

Name of Organization/Individual

Address **City, State** **Zip** **Phone**

Description of information to be exchanged / released / obtained:
❒ Education records
❒ Evaluation/assessment/eligibility records
❒ Medical records
❒ **Other**
❒ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies

Duration of release (check one):

❒ This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.

❒ From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

The purpose if this release is:_____

_____

Signature of Client/Parent/Guardian **Date**

_____

PRINT NAME and Relationship of Legally Authorized Representative to Student/Consumer/Client

Fee Schedule

Behavioral Consultation with Rosalie Byrd Prendergast, MS BCBA, Eugenia Logvinova, Med BCBA, Katherine Thomas, MS BCBA, Amanda Montoya, Med BCBA,:
$140 per hour plus $40 per hour traveled according to Google Maps.
In Home/School Behavior Therapy Masters level clinician:
$120 per hour plus $0.555 per mile traveled round trip according to Google Maps.
In Home/School Behavior Therapy with RBT Level Clinician Pursuing Certification:
$85 per hour plus $0.555 per mile traveled round trip according to Google Maps.
In Home/School Behavior Therapy with RBT Level Clinician:
$50 per hour plus $0.555 per mile traveled round trip according to Google Maps.
Additional Charges applying to all services:
These services maybe necessary for your program and are billed at your clinician's hourly rate.

- Phone consultation lasting more than 15 minutes.
- Written documentation (including progress reports and other forms of written communication) requiring more than 15 minutes
- Email messages requiring more than 15 minutes.
- Written or verbal communication with 3rd party payers (including insurance carriers, Community Centered Boards, etc.) requiring more than 15 minutes.
- Creation of individualized therapy materials such as, but not limited to books or stories requiring more than 15 minutes.
- Record review requiring more than 15 minutes.
- Other services a client may request requiring more than 15 minutes.

Please Sign in you understanding of the Fees Charged by Eclipse Therapy LLC.

_____ _____
Client/Parent/Guardian Date

Payment Policy

Eclipse Therapy LLC strives to offer the highest quality of care. Never will your care be contingent on your insurance or waiver coverage. Considerable care has been taken to determine our rates. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for optimal treatment. Our fees are comparable to those of other highly qualified specialists. Whether you have purchased insurance on your own, your employer has provided it to you, or you have qualified for a medicaid waiver, you are fortunate to have it and we will go the extra mile to help you maximize your benefits provided by your specific plan or waiver. As a courtesy to you, we will file with those plans to which we have been admitted as a provider (In Network) and when requested and we have not been admitted as a provider will complete the standard CMS1500 claim form for you to seek reimbursement through your insurer. When a service is covered, your insurance company usually only pays a percentage of the fee, and this varies from carrier to carrier and plan to plan. Your insurance is not designed to pay the entire cost of treatment, but it is intended to help cover a certain portion of the cost.

Please remember, however, the financial obligation for our services are between you and Eclipse Therapy, and is NOT between Eclipse Therapy and the insurance company.

For clients choosing to private pay for services, you will be billed monthly via our QuickBooks online accounting system. You will receive a bill between the 1st and 4th of the month following services. Payment for these services is due back 30 days from receipt of the invoice from Eclipse Therapy LLC.

Payment to our office is not contingent, nor dependent upon your insurance company. All account balances must be satisfied within 60 days of the date services were billed, after that time a rebilling fee of $10.00 may be charged to your account. If you have any questions regarding our financial policy, please do not hesitate to discuss them with us.

We accept cash, check, and bank transfers via QuickBooks online.

I understand and agree that I am responsible for the payment of all charges incurred regardless of any insurance coverage or other plans available to me. Additionally, I understand and agree to pay any and all collections costs and/or attorney's fees if any delinquent balance is placed with an agency or attorney for collection, suit, or legal action. I also acknowledge that confidentiality is waived in matters involving collections and the sharing of information sufficient to pursue recovery of debts owed.

_____ _____

Client/Parent/Guardian Date

Using Waiver Services

Type of waiver:

Community Center Board:

Case Manager Name:

Case Managers Email:

**Please fill out a release of information for us to contact your case manager **

Please note that we cannot begin services until we have Authorization in writing from your Case Manager.

Client/Parent/Guardian_____ Date _____

If you would like to begin services on a private pay basis prior to approval please sign bellow.

Client/Parent/Guardian _____ Date_____

Please sign in understanding that if you schedule session that go over the number of hours that you have approved through your waiver you will be billed at private pay rates.

Client/Parent/Guardian _____ Date_____

Using Insurance

*********Insurance coverage usually requires a diagnosis of Autism**********

Child's Name: _____

Date of Birth: _____

Child's Address: _____

Child's SS#: _____

Phone Number: _____

Insurance Company: _____

Insurance Company Phone Number: _____

Group Number: _____

Policy Number: _____

Plan Type: _____

Policy Holder's Name: _____

Date of Birth: _____

Policy Holders SS: _____

Employer: _____

Please attach a picture of the front and back of your card.

HIPAA Email Consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the *Health Insurance Portability and Accountability Act* HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted. Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL I understand the risks of unencrypted email and do hereby give permission to Eclipse Therapy LLC to send me personal health information via unencrypted email

_____

Client/Parent/Guardian Signature Printed name Date

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL I do not wish to receive personal health information via email

_____

Client/Parent/Guardian Signature Printed name Date

Please print email address_____

Assignment of Benefits

I authorize payment of behavior health benefits to Eclipse Therapy LLC and/or clinicians at Eclipse Therapy LLC for these services and all future claims. You should also understand you will be responsible for all non-covered services because of lack of authorization or for any other reason for denial.

_____

Client/Parent/Guardian Signature Date

I authorize the release of necessary medical information to process insurance claims.

_____

Client/Parent/Guardian Signature Date

Permission to Photograph

I give permission and consent for Eclipse Therapy, LLC to take photos of my child and/or myself during the time my child is enrolled in services. I understand these photographs may be used in educational training presentations.

Child's name:_____ Date of birth: _____

_____ _____ _____

Print name (parent/guardian) Signature (parent/guardian) Date

Permission to Videotape or Audiotape

I give permission and consent for Eclipse Therapy, LLC to videotape and/or audio tape my child and/or myself during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Eclipse Therapy, LLC and the family.

Child's name:_____ Date of birth: _____

_____ _____ _____

Print name (parent/guardian) Signature (parent/guardian) Date

In addition to the above, I also give permission for Eclipse Therapy, LLC to use recorded video segments to present to parents and professionals for conferences and/or other training purposes.

Child's name:_____ Date of birth: _____

_____ _____ _____

Print name (parent/guardian) Signature (parent/guardian) Date

CHILD & ADDOLESCENT INTAKE QUESTIONNAIRE

Confidential

The following questionnaire 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 in order to make the most productive and efficient use of our time. Please feel free to add any additional information, which you think, may be helpful in understanding your child. Eclipse Therapy, LLC will hold information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information.

PLEASE PRINT

Name of Person Completing this form: _____
Legal Name of Child/Adolescent: _____
Nickname or name child routinely goes by: _____
Child's Date of Birth: _____
Current Age: _____
Age of Diagnosis_____

Home Address (Primary Residence):
_____
_____
_____

Home Address (Secondary)
_____
_____
_____

Home Telephone Number (primary) : _____

Home Telephone Number (Secondary): _____

Work Telephone Number (Mother): _____

Work Telephone Number (Father): _____

Cellular Phone(s)

Mother:_____
Father:_____

School Name: _____

Grade:_____

School Telephone Number:_____

Current Teacher(s):

_____
_____
_____

Who referred you to our practice?

_____
_____

Please describe the problems your child is now having, and what type of services you are seeking from us for these problems. Please use the back of this page for additional space.

_____
_____
_____
_____

INDICATE PARRENT/GUARDIANS LIVING IN THE HOME

Marital Status: Married - Remarried - Divorced - Separated - Widowed - Single - Cohabitants
If divorced, who has physical custody? _____ Is it full or joint?_____

Who has legal custody? _____ Is it full or joint?_____

Mother's Name_____

Date of Birth: _____Age:_____

Occupation: _____SSN: _____

Employer:_____ email:_____

Education Completed_____

Health: ___Excellent ___Good ___Fair ___Poor

Father's Name_____

Date of Birth: _____Age:_____

Occupation: _____ SSN: _____

Employer:_____email:_____

Education Completed_____

Health: ___Excellent ___Good ___Fair ___Poor

Does either parent's job require him/her to be away from home long hours or extended periods? Yes/No

_____

_____

Religious/Spiritual Affiliation

_____

_____

Siblings

Name	Age	Relationship	School	Grade

Please list additional Siblings

PSYCHOLOGICAL HISTORY

Is there a history in your immediate or in the mother's or father's extended family, or the following and if so who?

Yes No		Who
	Autism Spectrum Disorders	
	Learning Problem/Disabilities	
	ADHD - ADD - Attention Problems	
	Depression & Manic - Depression	
	Behavior Problems in School	
	Anxiety Disorders (OCD, Phobias, etc.)	
	Mental Retardation	
	Psychosis/Schizophrenia	
	Substance Abuse/Dependence	

	Other Mental Health Concern (Please List)	

Has the child you are seeking services for been evaluated in the past? Yes/No
If Yes, please list the following information on the previous evaluation(s)

Who	Type	When	Copy Available
			Y/N
			Y/N
			Y/N
			Y/N

(If more evaluations need to be listed please use the space on the back of this page. If a copy is available please attach for your child's clinician to review)

If yes, what were their general findings and recommendations?

_____
_____
_____
_____

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child:

_____
_____
_____
_____

PRE-NATAL AND DELIVERY HISTORY

Were there any complications with the Pregnancy? Y/N

If Yes, please provide treatment details:

_____
_____

Was birth at Full Term? Y/N
If No, please provide detail:

_____
_____

Type of Delivery: Spontaneous/Induced Vaginal/C-Section

Complications? Y/N
If Yes, Please provide details:

_____
_____

Birth Weight: _____ lbs _____ oz Apgar Scores: _____ _____

Concerns at Birth? Y/N
If Yes, please provide detail - including any treatments given (Additional space on back if needed):

_____
_____

Is there any additional pre-natal or birth information that might be of assistance to us?

_____
_____

DEVELOPMENTAL HISTORY

1. Please indicate the age at which your child did the following:

Rolled over consistently	
Sat up unsupported	
Stood	
Crawled	
Walked	
Dressed Self	
1st words	
Said Intelligible work to stranger	
Used phrases	
Talked in Sentances	
Potty Trained During the Day	
Dry through the night (6+ months)	

2. Please indicate if your child is experiencing any of the following:

Problems with eating	
Isolated socially from peers	
Problems making friends	
Problems keeping friends	
Problems getting to sleep	
Problems controlling temper	
Nightmares	
Bed Wetting / Soiling	
Problems with authority	
Anxiety	
Unmotivated	
School concentration difficulties	
Grades dropping or consistently low	
Sadness or Depression	
Substance Abuse	

1. List any operation, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

   _____
   _____
   _____
   _____

2. List any medications your child is currently taking or has taken for extended periods (give dosage level if possible):

   _____
   _____
   _____
   _____

5. Child's current height: _____ Ft. _____Inches Weight:_____ Lbs.

6. With which hand does the child write: Right/Left

7. Does the child have any vision problems?

Please list date of last vision test and who performed (pediatrician, optometrist, School)

_____
_____

8. Does the child have any hearing problems?

_____
_____

Please list date of last hearing test and who performed (pediatrician, optometrist, School)

_____
_____

9. Name of child's physician(s)

_____
_____
_____

Practice Name:

_____
_____
_____

Address:

_____
_____

_____

Phone Number:

_____

Fax Number:

_____

(Please list information on additional Physicians on the back of the page)

EDUCATION HISTORY

1. List in chronological order all schools you child has attended:

Name	District	Year(s)	Grade

Special Ed?

2. Name(s) of current teacher(s)

_____
_____
_____

3. Does your child's teacher have concerns about him/her (list)

_____
_____
_____
_____
_____
_____

4. What is your child's favorite subject/class?

_____
_____
_____

5. What is your child's least preferred subject/class?

_____
_____
_____

6. Has your child ever repeated a grade? Y/N If yes, what grade(s)?:

_____
_____
_____

7. If your child has been in Special Education, did they have a:

504 Plan	
Occupational Therapy Evaluation	
Physical Therapy Evaluation	
Adaptive Technology Evaluation	
I.E.P.	
Psychological Evaluation	
Special Evaluation	
Behavior Intervention Plan	

8. If your child has been in Special Education, how were they served?

Consultation	
Resource Classroom	
Team Taught Classes	
Self-Contained Classroom	
Psycho educational Center	
Collaborative Education	
Pull-Out	
Special Program	

9. Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.

Football	Baseball
Cheerleading	Basketball
Karate	Piano
Scouts	Soccer
Dance (type)	Music (type)
Gymnastics (type)	

10. List any special abilities, skills, strengths your child has:

_____
_____
_____

ACADEMIC

Do you feel your child's academic skill level is appropriate? Y/N

_____
_____
_____
_____

Would you like us to address academic skills development? Y/N

_____
_____
_____
_____

Counting

Can your child identify numbers?
Single digit (1-9)____ all ____some _____none
Can count to 10 Y/N
Can count to 20 Y/N
Can count 20+ Y/N
Can your child count out a number of objects (e.g. Give me four pennies) Up to 5 objects Y/N
Up to 10 objects Y/N
10 + objects Y/N
Can your child identity double digit numbers? 10-99___all____some____none
Can he/she complete simple addition math problems? (Single digit) Y/N
Can he/she complete simple subtraction problems? Y/N

Other number skills:

_____
_____

Reading

Can your child identify letters?
Lowercase____ all _____some _____none
Uppercase____ all _____some _____none
Identify letter sounds____ all ____some ____none
Identify blends (e.g. sh, st, cr) Y/N
Can sound out words with blends Y/N
Can read simple words (2-4 letter simple words - cat, dog, sat) Y/N
Can read longer words and sight words (there, just, jump) Y/N
Can sound out unknown words Y/N
Can read simple sentences Y/N
Can comprehend what he/she is reading (can understand and answer questions about what's been read) Y/N

Reading Comments:

_____
_____

SELF CARE

Does your child dress him/herself? ____Independently _____with some assistance ____does not dress self
Does your child bathe him/herself? ____Independently _____with some assistance ____does not bathe self
Grooming (brushing teeth, combing hair)____independently ____some assistance ___does not
Does your child clean up after him/herself ____independently ____when asked ____does not

Do you have safety concerns regarding your child's activities at home? Y/N
Explain:

_____
_____
_____
_____
_____
_____

Self-Care Comments:

_____
_____

ATTENDING/ENGAGEMENT

Engagement:

Does your child make eye contact with others _____always _____sometimes _____never
Answer or look when name is called _____always _____sometimes _____never
Does your child follow gestures from others _____always _____sometimes _____never
Does your child engage in activities or games that are not their idea _____always _____sometimes _____never
Can your child appropriately play by him/herself ? Y/N
Respond with distraction:
Can your child answer questions when there is background noise, other people, distraction?
_____always _____sometimes _____rarely _____never
Does your child appear to understand directions and questions? _____strength _____challenge
Does your child appear to have a good memory? Y/N

Attending Comments:

_____
_____

BEHAVIOR

Tantrums/Aggression/Self-Injury: Does your child have tantrums that you feel need to be address?

Describe behavior:

_____
_____

What triggers a tantrum?
When told "no" (you can't have that/can't do that) Y/N
When he/she is not getting attention or wants attention Y/N
To avoid a non-preferred activity Y/N
To escape a non-preferred task/activity Y/N
For no obvious reason Y/N
Frequency___1 or more per month___1 or more per week___1 or more per day___1 or more per hour

Does your child react aggressively at times? Y/N
Describe aggressive behaviors:

_____

_____

What triggers aggressive behavior?
When told "no" (you can't have that/can't do that) Y/N
When he/she is not getting attention or wants attention Y/N
To avoid a non-preferred activity Y/N
To escape a non-preferred task/activity Y/N
For no obvious reason Y/N
Frequency___1 or more per month___1 or more per week___1 or more per day___1 or more per hour

Does your child engage in Self-injurious behavior (hurt himself or herself)?
Describe self-injurious behavior:

_____

_____

What triggers self injurious behavior?
When told "no" (you can't have that/can't do that) Y/N
When he/she is not getting attention or wants attention Y/N
To avoid a non-preferred activity Y/N
To escape a non-preferred task/activity Y/N
For no obvious reason Y/N
Frequency___1 or more per month___1 or more per week___1 or more per day___1 or more per hour
Physical Stereotypic Behavior:

_____

_____

Does your child flap his hands/arms Y/N
Does your child seem to look at his fingers in a stereotypic way Y/N
Does your child seem to look out of the side of his/her eyes Y/N
Does your child walk on his/her toes Y/N
Does your child rock (sit and rock back and forth) Y/N
Frequency___1 or more per month___1 or more per week___1 or more per day___1 or more per hour

Verbal Stereotypic Behavior:

_____

_____

Echolalia (repeats what is said/heard Immediate) Y/N
Delayed Echolalia (will repeat what's been said/heard later) Y/N
Self-talk Y/N
Humming to self - inappropriate Y/N
Screech or yell inappropriately Y/N for no apparent reason Y/N
Scrip videos or cartoon Y/N
Frequency___1 or more per month___1 or more per week___1 or more per day___1 or more per hour

Perseveration:

_____
_____

Does he/she get stuck on a topic Y/N
Get obsessive about specific people Y/N
Get obsession about specific objects Y/N
Frequency___1 or more per month___1 or more per week___1 or more per day___1 or more per hour

Transition/Routines:

_____
_____

Has trouble with sudden change Y/N
Has trouble with changes that they are warned about Y/N
Does your child fear any specific objects, animals, places or people? Y/N
Frequency___1 or more per month___1 or more per week___1 or more per day___1 or more per hour

Fears:
If yes, explain_____

_____
_____

SENSORY ISSUES

Does you child have sensitivity to (if yes explain):
Behavior Comments:

_____
_____

___Sound___Light___Touch___Texture
Frequency___1 or more per month___1 or more per week___1 or more per day___1 or more per hour

Sensory Comments:

_____
_____

IMITATION OF MOVEMENTS AND SPEECH

Can imitate movements when they are demonstrated (clap hands, touch head when someone else is doing the same and he/she is asked to "do this" or "clap hands") Y/N
Can imitate motions that go along with a song Y/N
Can imitate a word or words when told to "say_____" Y/N

Imitation Comments:

_____
_____

SPEECH:

Do you have concerns regarding dyspraxia or apraxia? Y/N If yes explain

_____
_____

Does your child repeat what he/she has heard other people or TV characters say? Y/N If yes Explain

_____
_____

Does your child use a communication system such as PECS, sign, augmentative device, etc? Y/N If yes explain

_____
_____

Speech Comments:

_____
_____

LANGUAGE

Does your child appear to understand language? ____no at all _____a little _____ this is a strength
Words in isolation - can identify objects when asked Y/N
Can identify actions ("where is the boy who is running" when shown a pictures of kids playing) Y/N
Can identify describing words (red vs. blue, big vs. little)__not at all ____a little ____strength
Can understand simple sentences ("drink your milk.") Y/N
Can understand more complex sentences ("go get your red shoes," or "give me the one that is not wet") Y/N
Can he/she follow directions? Y/N -_____one step _____two step _____three step with delay ("after you finish eating, go get your shoes")
Does your child use the following when speaking:
Nouns (people, places and things)____sometimes _____always ____never
Verbs (action words)____sometimes _____always ____never
Adjectives (describing words)____sometimes _____always ____never
Prepositions (in, out, on etc.)____sometimes _____always ____never
Pronouns (I, you, she, he)____sometimes _____always ____never
Simple sentences (3-4 word)____sometimes _____always ____never
Sentences w/descriptors ("It' s a black dog")____sometimes _____always ____never

Expressive Communication: Does your child use language?
To request needs/wants ____sometimes _____always ____never____
To greet others ___sometimes _____always ____never
To respond to greetings ____sometimes _____always ____never
Answer simple questions (what's your name?)____sometimes_____always ____never

Language Comments:

_____

_____

SOCIAL/PLAY

Does your child seek out social interaction with: ___adults ____siblings ____peers

Does your child play:
Independently___ sometimes____ always____ never
Next to but not with others ___ sometimes____ always____ never
With other children___ sometimes____ always____ never
With toys Y/N uses appropriately does not play with as intended ___ sometimes____ always____ never
Game skills plays games ___turn taking independently ___needs assistance ___independently
Verbal skills ___talks to peers during play ___talks to self ___does not talk

Social Comments:

_____

_____

FINE MOTOR SKILLS

Is your child ____left handed____ right handed ____no preference
Does your child hold a pencil properly? Y/N
Can he/she: Trace Y/N Copy letters Y/N Copy words Y/N

GROSS MOTOR SKILLS

Do you have concerns regarding your child's gross motor skills? Y/N Explain:

_____

_____

PARENT/FAMILY PRIORITIES & PREFERENCES

Top three areas/goals you would like to see change for your child in next 6 months:

1.

2.

3.

INTERVENTION STYLES

In order to accomplish goals set for your child, we rely on a variety of research-based methods and styles. We assess your child's needs and employ methods that will maximize your child's skill acquisition. Below you will see a list of various styles. We would like to understand your familiarity with each intervention type as those you think may think would work best for your child's personality/needs at this time. Pleases note that this is NOT an exhaustive list of methods.

STYLE/METHOD	**Familiar with style/method?**	**May use with my child?**
Errorless learning (teaching without	**Y N DK**	**Y N DK**

allowing errors)		
Fluency based instruction/precision teaching	**Y N DK**	**Y N DK**
Functional Communication Training	**Y N DK**	**Y N DK**
Incidental Teaching (following child's lead) around the house	**Y N DK**	**Y N DK**
Incidental Teaching (following child's lead) in structured play	**Y N DK**	**Y N DK**
One-to-one intervention (discrete trial) at desk or table	**Y N DK**	**Y N DK**
PECS (Picture Exchange Communication System)	**Y N DK**	**Y N DK**
Peer play dates	**Y N DK**	**Y N DK**
Positive Behavior Support working through behaviors and replacing behaviors with appropriate skills	**Y N DK**	**Y N DK**
Self-management plans (for behavior other skills)	**Y N DK**	**Y N DK**
Sign Language	**Y N DK**	**Y N DK**
Social Groups	**Y N DK**	**Y N DK**
Use of food as "reinforcer" (with the intent to fade as quickly as possible - we only use as a place to "start" if needed)	**Y N DK**	**Y N DK**

Are you currently seeing any ABA providers or other Behavioral Health Providers (psychiatrist, psychologist, counselor, ect) Y / N
If so please list and fill out a consent to release information for continuity of care:

_____
_____
_____

SUPPORTING BEHAVIORS

Sometimes when teaching our clients appropriate replacement behaviors, students may become upset or cry. When this happens, we are very adept at working through these instances with favorable outcomes. We want to understand how you feel about this when it happens. (Please note that all behavior support plans are discussed with parents and strategies for responding are explained and approved. Providers can debrief parents after any "difficult" sessions as well.)

_____ I am comfortable with letting my child cry and letting providers handle the situation
_____I am NOT comfortable with letting my child cry and letting providers handle the situation
_____I am unsure at this time

Comments:
_____
_____

DISCIPLINE INFORMATION:

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed:

Discipline Strategy	How Likely	Rating
Let situation go	1 2 3 4 5	
Take away a privilege (ex., no TV)	1 2 3 4 5	
Take away something material	1 2 3 4 5	
Assign an additional chore	1 2 3 4 5	
Physical Punishment	1 2 3 4 5	
Reason with child	1 2 3 4 5	
Send to room	1 2 3 4 5	
Ground child	1 2 3 4 5	
Send to time out	1 2 3 4 5	
Yell at child	1 2 3 4 5	
Ignore child	1 2 3 4 5	
	1 2 3 4 5	
	1 2 3 4 5	
	1 2 3 4 5	
	1 2 3 4 5	
	1 2 3 4 5	

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Please circle the LEAST effective.

Please rate what percentage of discipline is handled by each of the following: Father:_____% Mother:____% Other:_____% (Please Specify:)_____

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sister, etc.

Like Child to do More Often	Like Child to do Less Often
1._____	_____
2._____	_____
3. _____	_____
4._____	_____
5. _____	_____

Parent Guidelines and Policies

Your cooperation on the following is greatly appreciated to assist us in working with your child at an optimal level:

1. A parent or responsible adult must be in the home when therapy is being provided.
2. The therapist must wait 15 minutes if child is not there at the therapy time and then is allowed to leave. You may be charged for the session and this is not billable to insurance.
3. The telephone numbers of all therapists will be given to parents so they can contact their therapist directly. Please do not call the therapists before 8 am and not after 9 pm.
4. Parents should contact a therapist 24 hours prior to the appointment if the parent knows they are going to cancel a session. If more than 25% of sessions are cancelled in a 3-month period, your child may lose their therapy slot.
5. Sickness. Please notify the therapist, as much in advance as possible, at least the night,

before the scheduled session if you know that your child will not be able to participate in therapy the next day. Sickness includes, but not limited to the following:

   a. Temperature above 100
   b. Mumps
   c. Ring Worm
   d. Communicable Disease
   e. Chicken Pox
   f. Strep Throat
   g. Foot/Mouth Disease
   h. Measles
   i. Lice
   j. Vomit
   k. Diarrhea
   l. Rash
   m. Pink Eye

6. Parents are asked to use the same guidelines used in a school - if a child is too sick to attend school, he or she is too sick to participate in his/her therapy session. Therapy will resume as soon as the child's doctor clears him/her of being contagious or the remedy is completed. If a therapist arrives at the home and the child is sick, the therapist will not be able to work with your child.
7. The therapist will call/text the family if they are going to be arriving more then 5 minutes late.
8. If parents cancel a session, these hours are not made up unless the therapist agrees to do so.
9. If a therapist cancels a session, these hours may be made up as soon as possible depending on the therapist availability.
10. Therapy schedules should be consistent to reduce scheduling errors. Clearly there will be occasions like a doctors visit where a session may be moved, but that should be a rarity rather than the norm.
11. A therapist cannot change appointment times without agreement with the family.
12. In the case of snow or inclement weather:
    a. Please listen to the radio for announcements of school closing for the district in which you reside. If the district schools are closed it is an indication that driving in that area presents danger Eclipse Therapy therapist should not report to work that day.
    b. Since schools in the district are closed on inclement weather days, the time missed on those days can be made up at the discretion of the therapist and the family.
13. In case of an accident or unusual incident, the therapist should complete a form and inform the family and their supervisor within 1 business day.
14. Parents and therapist should be respectful and courteous to each other. Open

communication between parents and therapist is essential to the establishment of a successful program for the child. All communication must be done in a courteous and respectful manner. If there are any problems or concerns, please contact the BCBA or BCaBA Supervisor immediately.

15. Parents are encouraged to share with therapists any information that may be helpful in getting to know their child and will enable them to work successfully with the child.
16. Periodic videotaping of sessions may be helpful in assessing the progress of the child. Prior to a videotaping session, permission must be obtained by all parties involved and can be terminated at any time. Additionally, parents may request a copy of the taped session on a medium provided by them.
17. Eclipse Therapy feels that it is important to include all family members in therapy.
    a. Siblings are welcome to participate in therapy as long as they are a helpful addition to the session.
    b. Parents are welcome and should participate in therapy sessions.
    c. Cheat sheets specific to your child will be created. Therapist and supervisors will go over these in detail and provide modeling and coaching for you on these strategies.

Information Related to Scheduling and Sessions

Contacting us

Given their many professional commitments, our technicians are often not immediately available by telephone or email. If you need to leave a message, we will make every effort to return your call or email promptly (within 24 hours with the exception of holidays and weekends.). If you are difficult to reach, please leave some times when you will be available. Because of the nature of the services we provide, we do not provide on-call coverage 24 hours per day, 7 days a week. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

Services Offered

We will provide services specifically designed to help your child, or if we cannot help we will provide you with referrals to other professionals who may be able to serve your child and his/her needs. Our behavioral services consist primarily of assessments, in home/school behavioral services, parent training, and on going collaboration with other professionals.

Your child will have an ABA technician or team of ABA technician from Eclipse Therapy assigned to his/her case. Each technician has at least high school diploma and has completed a 40-hour training in Applied Behavior Analysis and varying experience providing services to children with Autism and other

behavioral/developmental difficulties. A Board Certified Behavior Analyst or Board Certified assistant Behavior Analyst oversees all cases.

ABA sessions are usually scheduled in two-three hour blocks. The research is clear that longer sessions result in greater retention and this makes scheduling more convenient for all parties. If this is not convenient for your family, please bring this up during at the intake meeting.

Except in cases of emergency, 24 hours notice is required for all cancelled appointments. Payment for the appointment is required for all missed appointments not cancelled according to this policy. Insurance carriers are **not** responsible for miss-appointment fees.

We request that families give us at least two weeks notice on significant changes in their plans for in-home ABA sessions scheduling in order to facilitate consistency in service delivery.

The standard of care outlined in the ABA International's Revised Guidelines for Consumers of Applied Behavior Analysis Services to Individuals with Autism includes supervision of therapists on an ongoing basis program consultation, program review, and program revision as services performed by a BCBA. These services are necessary for a program to meet minimum professional standards and are **not** optional.

Appointments

Except for rare emergencies, we will see your child at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitates the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you speak to your therapist personally and give as much notice as possible to cancel or reschedule. This will allow us to best plan for the situation.

You may be charged the standard hourly rate (see fee schedule) for appointments missed or cancelled with less than 24 hours advance notice. Please note that insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

Cancellation and Session Attendance Policy

Cancellations must be done no less than 24 hours prior to the scheduled session. If the client cancels more than two times without 24-hour notice, Eclipse Therapy can reduce or discontinue services.

Clients will participate in 80% of scheduled sessions per month. Otherwise, the client will have one month to reach 80% participation criteria, or Eclipse Therapy can reduction or discontinuation of services. Exceptions may be made if there are extreme medical conditions that require hospitalization, and a doctor’s note.

Clients will provide a minimum of 2 weeks notice for vacations lasting more than 3 days. If the client does not provide 2 weeks notice more than once, Eclipse can reduce or discontinue services.

Confidentiality, Records, and Release of Information

Services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions and as mandated by Colorado and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

To protect the client or others from harm

If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, and intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

Professional Consultations

Behavior Analysts routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them. We will tell clients about these consultations. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

Health Insurance

If we file your insurance claims, you are responsible for co-payment. You are also responsible for all or any portion of the bill that your insurance does not cover or denies.

Professional Records

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in one set of professional records. The Clinical Record includes information about reasons for seeking our professional services; the impact of any current or ongoing problems or concerns; assessment, consultative, or therapeutic goals; progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier.

Patients Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

Please sign stating you received the parent guidelines and policies

_____ _____

Client/Parent/Guardian Signature Date