West Texas Counseling & Guidance
36 E Twohig Avenue Suite 600
San Angelo, TX 76903-6433
Phone: 325-944-2561 | Fax: 325-939-2019

ABA Minor Intake Form

Date

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Client Information

Last Name | First Name | Middle Initial

Goes by Name: | Date of Birth | SSN

Address 1: | Address 2: | City

County | State | Zip Code

Sex ☐ Female ☐ Male ☐ Other

Home Phone | Mobile No.

Caregiver Information

Caregiver Name:

Caregiver Phone Number:

Caregiver Address:

Caregiver Name:

Caregiver Phone Number:

Caregiver Address:

Emergency Contact

Name: | Contact Number:

Relationship to Client:

Insurance Information

Primary Insurance Name:

Phone Number of Insurance:

Policyholder Name:

Policyholder Date of Birth:

Insurance ID:

Insurance Group Number:

Secondary Insurance Name:

Phone Number of Insurance:

Policyholder Name:

Policyholder Date of Birth:

Insurance ID:

Insurance Group Number:

Family Information

Parents

Mother Living (Age)

Deceased (Date)

Father Living (Age)

Deceased (Date)

Siblings

How Many?

I am: ☐ The oldest ☐ In the middle ☐ The youngest ☐ An only child

Who lives at home with you?

Has the child or anyone in the family experienced domestic violence or abuse? ◯ Yes ◯ No

Is the child currently experiencing/witnessing domestic violence or abuse? ◯ Yes ◯ No

Religion/denominational preference:

Congregation (if any):

Medical History of Client

Primary Physician

Date of Last Medical Exam

List any physical illness or symptoms experienced at this time

List major surgeries or illnesses in the last five years

List any current medication(s). Include name(s) of any medication(s), dosage(s), how often and when medication(s) is taken, and any reaction(s) or side effect(s)

Is the child receiving speech therapy services? Yes No

If yes, provider name and info:

Is the child receiving occupational services? Yes No

If yes, provider name and info:

Is the child receiving physical therapy services? Yes No

If yes, provider name and info:

List the child's diagnosis:

Date of diagnosis:

Name of diagnosing provider:

Additional diagnosis:

Is there a family history of ASD or related disorders? Yes No

If yes, please explain:

Developmental History

Age first sat up:		Age first rolled over:		Age first walked:		Age said first word:	
Age able to feed self:		Age toilet trained:		Age able to dress self:		Age able to sleep through the night:	
Age first slept in own bed:							

Mental Health History

Has your child experienced mental health problems before? ◯ Yes ◯ No

If yes, explain:

Do you have a family history of mental health problems? ◯ Yes ◯ No

Has your child ever received behavioral services with another provider? ◯ Yes ◯ No

If yes, explain:

Has your child ever been hospitalized or received inpatient treatment for mental health issues? ◯ Yes ◯ No

If yes, when and where:

Have you or someone in the family ever lost someone you care about to suicide? ◯ Yes ◯ No

If yes, who and when?

Please indicate if your child/adolescent engages in any of the following behaviors (check all that apply)

Aggressive Behavior

☐ Hitting (punching, slapping, etc) ☐ Kicking ☐ Biting ☐ Pinching ☐ Head butting

☐ Scratching ☐ Spitting

☐ Other (Please specify)

Self Injurious Behavior

☐ Hitting self with hands or fists (list where on body):

☐ Kicking self with hands or fists (list where on body):

☐ Biting self with hands or fists (list where on body)

☐ Headbutting walls,windows, etc. ☐ Pulling teeth ☐ Scratching skin ☐ Cutting/burning

☐ Other (Please specify)

Other Behaviors

☐ Pulling teeth

Please describe:

Other Behaviors (continued)

☐ Sensory issues

Please describe:

☐ Sexualized behaviors

Please describe:

☐ Eloping (running out building, room, vehicle, etc)

☐ Self urinating/defecating

☐ Fecal smearing

☐ Rectal digging

☐ Difficulty with toileting

☐ Defiance or problems with authority

☐ Problems with eating

☐ Tantrums

☐ Screaming/yelling

☐ Vocalizations

☐ Repetitive Behaviors

☐ Other behaviors

Please describe:

Additionally, please indicate if your child is experiencing any of the following (check all that apply)

☐ Socially isolated from peers

☐ Difficulty making friends

☐ Problems keeping friends

☐ Sleep problems

☐ Bedwetting

☐ Fire Setting

☐ Anxiety

☐ Sadness/ Depression

☐ Hallucinations

☐ Delusions

☐ Suicidal ideations/ attempts

☐ Legal situations

☐ History of physical abuse

☐ History of sexual abuse

☐ Alcohol Use/Abuse

☐ Difficulty concentrating

☐ Drug use/abuse (nicotine and illegal drugs)

If yes, list drugs:

Are there any current or past relevant legal issues pending with your child? ◯ Yes ◯ No

If yes, please provide details:

Discipline Information

Please rate what percentage of discipline is handled by each of the following:

Parent/Guardian 1:		Percentage:		Relationship to the child:	
Parent/Guardian 2:		Percentage:		Relationship to the child:	

What is typically used for disciplining your child? (e.g. timeouts, assigning chores, physical/corporal punishment, etc.)?

Are there any spiritual or cultural beliefs that may impact how you provide discipline or behavioral supports to your child? ◯ Yes ◯ No

If yes, please provide details:

Goals & Additional Info

Please state what goals you have for your child while engaging in ABA therapy:

What other information is important for your therapist to know?

Crisis Management Plan:

I understand that in the event of an emergency/crisis, or if the therapist is unable to clearly determine factors to ensure my own safety or that of someone else in the middle of my session, my therapist has the right to contact the following individuals for additional assistance:

1) Personal Contact:_____

   Phone Number(s):_____

2) Personal Contact: _____

   Phone Number(s):_____

3) Professional Contact:_____

   Phone Number(s):_____

I understand if deemed necessary, my therapist may request a Welfare Check to be completed, contact local authorities and/or 911. Lastly, my therapist may also make recommendations for alternative treatment or refer me for a next available crisis appointment with WTCG staff.

Acknowledgement of these forms

The information written on this packet is accurate, to the best of my knowledge.

_____ _____

Signature of Parent / Guardian / Client Date

WEST TEXAS
COUNSELING & GUIDANCE

No Shows, Cancellations, & Payment for Services

Client Name: _____

When you schedule an appointment with our staff, West Texas Counseling & Guidance reserves that time just for you. If you are not going to attend your scheduled appointment, we would like to give another client the opportunity to take that opening. It affects our funding, our ability to budget our staff, and staff salaries when there are missed appointments. That is why we require **24-hour advance notification of cancellation**. Leaving a message with our answering service is fine, even on weekends. The time you called will be posted with the message. If you do not give 24 hours' notice before cancelling your appointment, do not show for your appointment, and/or are more than 15 minutes late more than two times in a three-month period, you may be asked to schedule with another therapist or moved to the WTCG wait list for services. Clients may also be charged a **$50 missed fee** prior to being seen again. If you are being seen for reduced fee and pay less than $50 per session, the fee will be your usual session charge. Those seen without a session fee will be charged $5 per missed session.
Clients with certain insurances cannot be billed the missed appointment fee - Medicaid, Employee Assistance Programs (EAP), or some private insurances. We appreciate the courtesy you extend to us by honoring this agreement. Please note that **we cannot bill your insurance company for missed sessions** or for late cancellations. All clients scheduled to be seen in the appointment must be present in order for the appointment to be considered kept (both partners for couples counseling, etc.)

Certain insurances may not reimburse for some services offered at WTCG; in the event that insurance does not reimburse for a service provided and the client does not qualify for one of several client assistance programs at WTCG, the client will be held responsible for payment for that service.

Counselor Discretion: The counselor may choose to continue to see the client without requiring same- day appointments. The counselor may also waive the $50 fee.

Weather Related: Missed appointments due to dangerous weather will not count as a late cancellation. Due to the counselors maintaining a set schedule:

- If you are 15 minutes late for 60-minute appointment, you may not be seen.
- If you are 10 minutes late for a 45-minute appointment, you may not be seen.
- If you are 5 minutes late for a 30-minute appointment, you may not be seen.

Court appearance: In the event disclosure of your records or the therapist's testimony are requested by you or required by law, you will be responsible for the costs involved in producing the records and the therapist's normal **hourly rate of $104.00** for giving that testimony. If a clinician is required to travel to a court location out of town, per diem and mileage are additional costs that you will be responsible for. Such payments are to be made prior to the time the services are rendered by the therapist.

By signing this agreement, I acknowledge my understanding of all the policies listed above. I accept and agree to all of the above terms during the course of my treatment at West Texas Counseling & Guidance.

_____ _____
Signature of Parent / Guardian / Client Date

_____ _____
Signature of WTCG Staff Date

WEST TEXAS
COUNSELING & GUIDANCE

Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices

Client Name: _____

I have been provided with a printed copy of the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet. In addition, the therapist/counselor/clinical social worker has provided a verbal explanation of psychotherapy/counseling/clinical social work services and privacy practices, to include exceptions to confidentiality. I have been afforded an opportunity to review the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet, other pertinent information, and to ask questions. All questions have been answered to my satisfaction. I am making an informed decision, free of any coercion, to engage in psychotherapeutic/ counseling/clinical social work services, and for purpose of research to have my non identifiable information used. If I would like to withdraw my non-identifiable information from data collection and evaluation, I must submit this request in writing to reception@wtcg.us. I understand that I will not be denied services based on my withdrawal from data collection.

If deemed necessary or appropriate to participate in telecounseling services at West Texas Counseling & Guidance, I agree to the Informed Consent for Telehealth/Telecounseling provided in the Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices**.** I have the opportunity to discuss the telehealth policies with my therapist and ask any questions I may have in regard to telecounseling services prior to participation.

_____ _____
Signature of Parent / Guardian / Client Date

_____ _____
Signature of WTCG Staff Date

TREATMENT CONTRACT

We are entering into this contract with West Texas Counseling & Guidance ABA program voluntarily. This contract will remain in effect from today's date until either party wishes to terminate this agreement by giving written notice.

We agree to cooperate with our provider's efforts to offer services to our child and our family and we will participate in the treatment process and will follow through with any interventions recommended by our ABA provider(s). We understand that failure to comply with treatment and/or participate in parent training may be grounds for dismissal and termination of ABA services through WTCG.

If an additional therapist is working with our family, a Board Certified Behavior Analyst (BCBA) will supervise and monitor services provided to us and our child, as well as provide supervision for the therapist/s.

I/we understand that our WTCG ABA provider shall have exclusive responsibility and authority to make all professional judgments and decisions with reference to the services rendered to me/us and our family.

I/we understand that a there will be a minimum number of hours (determined by the treatment plan) to adequately supervise (by a Board Certified Behavior Analyst) all involved caretakers, observe my child engaging in the recommended program, and make changes to his/her program. I/we agree to meet for a 15 minute debrief following the end of every session. Additionally, that I/we must participate in a progress meeting 1 time a month to review my child's progress and to discuss any changes to my child's program.

I/we understand that ABA therapy will incur substantial costs in providing and arranging for the services to be provided to our family, including supplies, services, personnel, and other items that are subject to this agreement. Accordingly, I/we promise and agree that, during the term of this agreement, and any extension to the agreement:

1. I/We will not attempt to directly or indirectly own, manage, operate, control, or participate in the ownership, management, operation or control of, or become associated, as an employee, director, officer, advisor, agent, consultant, principal, partner, member or independent contractor with any person, enterprise, firm, partnership, corporation, limited liability entity, cooperative, or other entity operating a behavioral consulting services firm or other ABA service provider.
2. I/We will not attempt to divert any business of WTCG to any other ABA service provider.
3. I/We agree not to solicit or employ any employee or independent contractor of WTCG, including Board Certified Behavior Analysts, consultants, therapists, or any other employees, in any manner including, but not limited to, as an employee, consultant, or

through a third party, other than general advertisement without prior written approval by Jonathan Blann during the term of this agreement.

4. I/We agree to maintain confidentiality for all business policies, procedures, techniques, trade secrets, other knowledge, or processes developed by WTCG ABA Program. I/We understand that all program materials are prepared solely for my/our use and cannot be copied, disseminated, published, or shared with a third party without the approval of WTCG ABA Program. I/We understand that all program materials must be returned to WTCG ABA Program upon termination of this agreement.

I/We understand that there is a risk associated with any type of therapy or intervention, however, WTCG ABA provider(s) will do everything possible to minimize risks. I/We agree that to the fullest extent permitted by law, WTCG shall not be liable to the Client for any special, indirect, or consequential damages whatsoever, whether caused by ABA program negligence, breach of contract, or other cause or causes whatsoever including, but not limited to, loss of behavioral consulting services and the costs related to locating a new provider of such consulting services. This does not include willful or intentional wrongs. I also understand that therapy outcomes are dependent on several variables and success cannot be guaranteed. I understand that failure to adhere to treatment recommendations by WTCG ABA Program staff may impact the success of my child's progress and that I am responsible for being a willing and active participant in this process. I understand that continual non-compliance with adhering to treatment recommendations may result in termination of services.

Parent/Guardian #1: _____
(Print Name)

Parent/Guardian #1: _____ Date: _____
(Signature)

Parent/Guardian #2: _____
(Print Name)

Parent/Guardian #2: _____ Date: _____
(Signature)

Name of BCBA: _____
(Print Name)

Name of BCBA: _____ Date: _____
(Signature)