Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Intake Form Date: Location:

Discipline:	☐ Behavioral Therapy	☐ Speech Therapy	☐ Occupational Therapy	☐ Physical Therapy

Patient Information

Last Name:		First Name, Initial:	
Age:	DOB:	Sex: ☐ Male ☐ Female	Grade:

Parent/Guardian Information

Parent/Guardian Name:		Parent/Guardian Name:		
Street Address:		City:	State:	Zip:
Phone #:	Phone #:	Email Address:		

Referral Information

☐ Provider	☐ Internet/Google	☐ Other:

Referring or Primary Care Physician Information

Referring Physician:	Physician Phone #:
Physician Address:	Physician Fax #:
Primary Care Physician:	Physician Phone #:
Physician Address:	Physician Fax #:
When was your last visit to your primary doctor?	Did you discuss therapy with your primary doctor? ☐ Yes ☐ No
Have you been treated by another facility in the past calendar year?	☐ Yes ☐ No
If yes, Where?	Facility Phone #:

Primary Insurance Information

Insurance Name:	Benefits Phone #:		
ID or SSN:	Group Number:		
Patient's relationship to subscriber:	☐ Self	☐ Child	☐ Other
Subscriber's Name:	DOB:		

Secondary Insurance Information (if any)

Insurance Name:	Benefits Phone #:		
ID or SSN:	Group Number:		
Patient's relationship to subscriber:	☐ Self	☐ Child	☐ Other
Subscriber's Name:	DOB:		

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Patient Name:	**ID:**	
General Questions		
What would you like me to call you?		
Why are you coming to Cole?		
Has your child ever been diagnosed with anything? If yes, please list.	☐ Yes	☐ No
Do you have a clear understanding of the diagnoses?	☐ Yes	☐ No
Do you participate in any community support groups (social services, school based services, play groups, church groups)? Please list.	☐ Yes	☐ No
Did you have a healthy pregnancy? (If parent answers no, then ask the following questions) a. Was your child born at 36-40 weeks? (If earlier than 36-40 weeks please ask at what week child was born) b. Did you have complications during delivery? If yes, could you please give details on the complications?	☐ Yes	☐ No
Does your child have allergies such as latex? Food (eggs, wheat, peanuts)? Environmental?	☐ Yes	☐ No
Does your child have drug allergies? Please list	☐ Yes	☐ No
Is your child currently taking any medication over the counter or prescription? If so, please list medications.	☐ Yes	☐ No
Does your child wear glasses? Please bring glasses for appointment. When was your child's last vision exam?	☐ Yes	☐ No
Does your child have difficulty hearing? (If yes then ask the following question) Does your child wear hearing aids or a cochlear implant? If so please bring to the evaluation. When was your child's last hearing exam?	☐ Yes	☐ No
Has your child had a history of seizures? If yes, how often (weekly, monthly, annually)?	☐ Yes	☐ No
Has your child had a recent injury? If so, please bring doctor's release so we are aware of any physical activities the child should/shouldn't do.	☐ Yes	☐ No
Is your child seeing any other doctors or medical specialists (including behavioral therapist)? If so, please list types of doctors and dates of service.	☐ Yes	☐ No
Is your child verbal?	☐ Yes	☐ No
Does your child show any of the following behaviors on a regular basis: tantrums, screaming, biting, hitting, kicking, throwing, spitting, and/or pinching?	☐ Yes	☐ No
What are your main concerns?		
Behavior Therapy Questionnaire		
Does your child exhibit aggression to the Environment/Property (AE), such as throwing/turning over/ destroying materials)? List behaviors.	☐ Yes	☐ No
Does your child exhibit aggression towards other people? List behaviors (biting, hitting, scratching, etc.)	☐ Yes	☐ No
Does your child exhibit aggression towards self? List behaviors (biting self, hitting self, etc.)	☐ Yes	☐ No
Does your child exhibit verbal aggression towards other people? List behaviors (yelling, screaming, etc.)	☐ Yes	☐ No
Does your child wander away from you?	☐ Yes	☐ No
Does your child drop/fall to ground unexpectedly?	☐ Yes	☐ No
Does your child exhibit ingestion of inedible substances?	☐ Yes	☐ No
Does your child exhibit inappropriate sexual behaviors?	☐ Yes	☐ No
Does your child exhibit grabbing items that do not belong to them?	☐ Yes	☐ No
Does your child exhibit non-compliant behavior? If yes, list inappropriate behaviors.	☐ Yes	☐ No
Does your child respond to student environmental changes (loud noises, people leaving room)? If yes, how do they respond?	☐ Yes	☐ No
Does your child exhibit motor or vocal self-stimulatory behaviors (making noises, hand flapping, or rocking)? If so, what behaviors?	☐ Yes	☐ No
How long can your child remain seated?	☐ Less than 1 minute	☐ Up to 5 minutes / ☐ From 5-10 minutes

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Patient Name:	**ID:**		
In a day, how much time is spent engaged in dealing with inappropriate behavior?	☐ Never or between 1-2 times per day	☐ Between 3-4 times a day	☐ More than 4 times a day
How long is your child engaged in inappropriate behavior throughout the day?	☐ Never or less than 1 hour per day	☐ Between 1-2 hours per day	☐ More than 2 hours per day

Physical Therapy Questionnaire		
Can your child sit alone for 10 minutes?	☐ Yes	☐ No
Can your child walk without support?	☐ Yes	☐ No
Can your child jump off floor with 2 feet?	☐ Yes	☐ No
Can your child stand on one foot with help?	☐ Yes	☐ No
Can your child go up and down stairs?	☐ Yes	☐ No
Has your child had an MRI or X-Ray? If yes, please describe.	☐ Yes	☐ No
Occupational Therapy Questionnaire		
Does your child show sensory issues such as sensitive to loud noises, light, food, haircuts, brushing teeth?	☐ Yes	☐ No
Does your child have difficulty with buttoning, using scissors, handwriting?	☐ Yes	☐ No
Can your child sit at the table for 7-10 minutes to complete a task?	☐ Yes	☐ No
How much help does your child need to get ready in the morning?		
Speech Therapy Questionnaire		
Does your child have difficulty pronouncing sounds?	☐ Yes	☐ No
Do you and other people understand what your child says?	☐ Yes	☐ No
Does your child understand when you give him/her directions?	☐ Yes	☐ No
Does your child have any problems eating different foods/is your child a picky eater?	☐ Yes	☐ No
Does your child have any problems talking/playing with other children?	☐ Yes	☐ No
Does your child have any difficulties with stuttering?	☐ Yes	☐ No
Has your child been exposed to any other language than English? (If so, continue with questions below)	☐ Yes	☐ No

Which language(s) do you speak to your child in?	☐ English	☐ Spanish	☐ Both
Which language(s) does your child know better?	☐ English	☐ Spanish	☐ Both
Which language(s) does your child watch television in?	☐ English	☐ Spanish	☐ Both
Which language(s) does your child use when speaking to brothers/sisters or friends?	☐ English	☐ Spanish	☐ Both
Which language(s) does your child's teacher usually use in the classroom?	☐ English	☐ Spanish	☐ Both
Which language(s) does your child usually read and write in?	☐ English	☐ Spanish	☐ Both
Which language would you like for this test to be given in?	☐ English	☐ Spanish	☐ Both

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Patient Name:	**ID:**

Medical History

Has the patient had tubes placement in ears?	☐ Yes	☐ No	If so, when:
Has the patient had any surgeries?	☐ Yes	☐ No	If yes please list type/date:
Has the patient ever been hospitalized or to the ER?	☐ Yes	☐ No	If yes, when and why:

Has your child been diagnosed with any of the following:

☐ Fifth Disease	☐ Tuberculosis
☐ Dysentary	☐ Malaria
☐ Lice	☐ Polio
☐ Hepatitis A	☐ Whooping Cough
☐ Hepatitis B	☐ Measles
☐ Hepatitis C	☐ Other: _____

Has anyone in the family been diagnosed with any of the following:

☐ Autism	☐ ADD
☐ Down Syndrome	☐ ADHS
☐ Learning Disabilities, Dyslexia	☐ Depression
☐ Seizure Disorder	☐ OCD
☐ Auditory Processing	☐ Social Anxiety Disorder
☐ Schizophrenia	☐ Bipolar
☐ Personality Disorder	☐ Other: _____

If checked, how is relative related to your child (sibling, uncle, grandfather, etc.)

Diet/Feeding

Please describe the patient's diet: (check all that apply)	Where does the patient eat? (check all that apply)	Please indicate what items the patient can use: (check all that apply)	
☐ Regular	☐ At the table on a chair	☐ Spoon	☐ Cup (no lid)
☐ Soft foods	☐ Highchair	☐ Fork	☐ Straw
☐ Puree	☐ Booster seat	☐ Knife	☐ Sippy cup
☐ Liquids	☐ Wheelchair	☐ Needs assistance	☐ Bottle
☐ Bolus Feeding	☐ Other:	☐ Other:	☐ Other: _____

Does the patient have special diet needs?	☐ Yes	☐ No	If yes, please describe:		
Does the patient have feeding or swallowing issues?	☐ Yes	☐ No	If yes, Has a swallow study been done?	☐ Yes	☐ No
Can the patient finger feed him/herself?	☐ Yes	☐ No	Can the patient pour from a large pitcher?	☐ Yes	☐ No
Is the patient a picky eater?	☐ Yes	☐ No	Open container and remove food?	☐ Yes	☐ No
If in a wheelchair, is your child positioned upright?	☐ Yes	☐ No			

Developmental / Speech History

Please indicate the patient's developmental history/age:				Is the patient frustrated?	☐ Yes	☐ No
☐ Crawl	Age:	☐ Feed self	Age:	What Primary language is spoken at home?	☐ English	☐ Spanish
☐ Sit	Age:	☐ Use Toilet	Age:	What Primary language do siblings speak?	☐ English	☐ Spanish
☐ Stand	Age:	☐ Dress self	Age:	What language does the patient speak at school?	☐ English	☐ Spanish
☐ Walk	Age:	☐ Use single words	Age:	What Primary language is television watched?	☐ English	☐ Spanish
Are there any other speech, language, learning, hearing, or mobility problems in your family?					☐ Yes	☐ No

If yes, please describe:

Additional Notes:

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Patient Name:	**ID:**

Developmental / Speech History Continued

The patient has difficult with: (check all that apply)	Does the patient communicate using: (check all that apply)	Does the patient: (check all that apply)	At what age did the patient begin speaking?
☐ Talking ☐ Pronunciation ☐ Understanding ☐ Conversation ☐ Asking questions ☐ Other:	☐ Gestures ☐ Single words ☐ Short phrases ☐ Sign language ☐ Pictures	☐ Stutter ☐ Make sounds ☐ Grunts ☐ Babble ☐ Speak in a low/hoarse voice ☐ Speaks in-complete sentences ☐ Cuts off words	☐ 1-2 years ☐ 3+ years ☐ Doesn't speak ☐ Other

Give me an example of how the patient speaks:	How many words does the patient use: ☐ 0 ☐ 2-10 ☐ 10-20 ☐ 50+
What is the main concern?	
How does the patient interact with others?	

Physical/Coordination			**Sensory Continued**		
Alternate feet going down stairs	☐ Y	☐ N	Gets anxious in crowded places	☐ Y	☐ N
Crawls forward	☐ Y	☐ N	Obsessive with objects or ideas	☐ Y	☐ N
Jumps off floor with 2 feet	☐ Y	☐ N	**Dressing**		
Kicks large ball	☐ Y	☐ N	Unties and removes shoes	☐ Y	☐ N
Runs smooth at different speeds	☐ Y	☐ N	Ties shoelaces in a bow	☐ Y	☐ N
Sits along for 10 minutes	☐ Y	☐ N	Puts on/removes socks	☐ Y	☐ N
Stands on 1 foot with help	☐ Y	☐ N	Puts on/takes off lower body clothes	☐ Y	☐ N
Uses pedals on tricycle	☐ Y	☐ N	Can use fasteners (snaps, button, Velcro)	☐ Y	☐ N
Walks upstairs holding rail	☐ Y	☐ N	**Bathing**		
Walks without support	☐ Y	☐ N	Bathes without assistance	☐ Y	☐ N
Walks on his/her toes	☐ Y	☐ N	Washes & dries face	☐ Y	☐ N
Sensory			**Hygiene**		
Fussy or irritable as a baby	☐ Y	☐ N	Blows & wipes nose	☐ Y	☐ N
Sensitive to light	☐ Y	☐ N	Brushes & combs hair	☐ Y	☐ N
Covers ears for loud noises	☐ Y	☐ N	Brushes teeth	☐ Y	☐ N
Dislikes haircuts and/or washing hair	☐ Y	☐ N	**Toileting**		
Flaps hands and/or fingers	☐ Y	☐ N	Toilets independently	☐ Y	☐ N
Has difficulty standing in line	☐ Y	☐ N	Requests diaper change	☐ Y	☐ N
Does not seem to hear &/or ignores when called	☐ Y	☐ N	Can tell adult when he/she needs to use the restroom	☐ Y	☐ N
Likes to run around/spin in circles	☐ Y	☐ N	Can the patient tell the difference between urine & bowel movements?	☐ Y	☐ N
Likes crashing/bumping into things	☐ Y	☐ N	Manages clothes after toilet use	☐ Y	☐ N
Overly aggressive hits/hugs too hard	☐ Y	☐ N	Manages toilet, seat, paper & flushes	☐ Y	☐ N
Has difficulty going down stairs	☐ Y	☐ N	Washes hands thoroughly after toileting	☐ Y	☐ N
Has difficulty jumping off objects	☐ Y	☐ N			

Additional Notes (if applicable):

Signature of Parent or Legal Guardian and relationship	Date

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Patient Bill of Rights

Patient Name:	ID:

The Patient's Bill of Rights and Responsibilities has three goals:
To strengthen consumer confidence that the health care system is fair and responsive to consumer needs; to reaffirm the importance of a strong relationship between patients and their health care providers; and to reaffirm the critical role consumers play in safeguarding their own health. The Commission articulated seven sets of rights and one set of responsibilities:

The Right to Information:
Patients have the right to receive accurate, easily understood information to assist them in making informed decisions about their health plans, facilities, and professionals.

Being a Full Partner in Health Care Decisions:
Patients have the right to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parent, guardians, family members or other conservator. Additionally, provider contracts should not contain any so-called "gag clauses" that restrict health professionals'' ability to discuss and advise patients on medically necessary treatment options.

Care without Discrimination:
Patients have the right to considerate, respectful care from all member of the health care industry at all times under all circumstance. Patients must not be discriminated against in the marketing or enrollment or in the provision of health care services, consistent with the benefits covered in their policy and/or as required by law, based on race, ethnicity, national origin, religion, sex, age, current, or anticipated mental or physical disability, sexual orientation, genetic information, or source of payment.

The Right to Privacy:
Patients have the right to communicate with health care providers in confidence and to have the confidentiality of their individual-identifiable health care information protected. Patients also have the right to review and copy their own medical records and request amendments to their records.

The Right to Speedy Complain Resolution:
Patients have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

Taking on New Responsibilities:
In a health care system that affords patients' rights and protections, patients must also take greater responsibility for maintaining good health.

Complaints and Appeals:
If you have questions or comments regarding the Patient Bill of Rights, please contact President, Jason Stark, or his designee, when the President is not available.

To reach the President, please write or call the following location:
16835 Deer Creek Dr. Ste. 200
Spring, TX. 77379
281-379-4373

Cole Health
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Comprehensive Treatment Plan Agreement

Patient Name:	**ID:**

It is understood that Cole Speech & Language, Cole Consolidated, Northeast Rehab, Cole ABA Solutions (DBA Cole Pediatric Therapy, Cole Rehabilitation, and Cole Academy), hereinafter will be referred to as Cole Health.

In order to provide the best services for our patients, we ask you to please read and acknowledge that you agree to abide with the policies outlined by signing where indicated. These policies are effective September 1, 2005. If you have any questions about these policies please ask a representative of this center before signing.

Acknowledgement of Receipt

- I have received and have had the chance to have explained, the Patient Bill of Rights.

Acknowledgement of Risk

- I understand that there is some risk inherent in the use of therapeutic equipment at this Center, and I agree to indemnify and hold the center harmless for any and all losses and claims for any injuries occurring to my child or myself from the use of therapeutic equipment.
- If you/your child is receiving therapy via Telehealth:
  I understand that there are potential risks to the use of this technology, including but not limited to interruptions, authorized access by third parties, and technical difficulties. I am aware that either my/the patient's therapist or I can discontinue the telehealth service if we believe that the videoconferencing sessions are not adequate for the situation.

Advance Directives

☐ I have or ☐ I have not signed a ☐ Living will Advanced Directive or ☐ Out of Hospital DNR. ☐ I am ☐ I am not providing a copy for my record.

Medical Power of Attorney: **Telephone Number:**

Agreement to the following Code of Conduct and Responsibilities

- Behavior that shows respect and consideration for other patients, family, visitors and personnel of the Center.
- In order to receive maximum benefit from therapy, it is important for therapy to occur every day and I am responsible for ensuring my child is available at the designated time. If for any reason I cannot be present for any visits in a timely manner, I am responsible for promptly notifying Cole Health and following the guidelines as outlines in the cancellation policy.
- I am responsible for learning and following through with techniques and activities presented to me in order to complete my child's treatment plan.
- I understand that I am responsible for waiting with my child in the waiting room until the treatment session begins and monitoring my child's play in the waiting room.
- If applicable, I understand that the Center prefers I wait during the session if not participating so that I am able to monitor some of my child's treatment when appropriate. I understand that it is the policy of this Center that a parent or legal guardian must remain in the Center during treatment sessions unless other arrangements have been and we have an emergency contact number.
- I will know how to contact my child's physician and comply with his/her instructions.
- I will keep Cole Health. informed of any changes in my child's medical care including hospitalizations or emergency room visits.
- I will keep Cole Health. informed of any changes in my child's insurance benefits as soon as I am aware of them to avoid services being placed on hold.

Complaint or Grievance Policy

- I understand that should I have a complaint, I am to report it to the office immediately. If you feel the complaint isn't resolved satisfactorily or in a timely manner you may contact the Director.

Non Discrimination Policy

- Cole Health does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy contact the Director.
- Speech, Hearing (Relay Texas) and Visual assistance communication guides are available at no charge and upon request. For further information about this policy, contact the Director.

Speech, Occupational, and Physical Therapy Scheduling Policy and Consent to Treat

- I hereby consent to treatment services and understand that once an appointment schedule has been established, the Center may not be able to accommodate short term scheduling changes. When a permanent change in time is needed, I must give as much advanced notice as possible for the Center to attempt to accommodate this request. A change in time may necessitate a change in therapists. Most therapy sessions are based on 30-50 minute treatment session followed by a five (5) to ten (10) minute conference with the parent/guardian. Late arrival for an appointment may result in a shorter therapy session or cancellation of the therapy session.
- I understand that the Center is open from 8 a.m. to 8 p.m. Monday through Friday and Saturday through Sunday from 8 a.m. to 6 p.m. however, hours vary by location. During times of severe weather, it is my responsibility to call the Center to determine whether changes in the scheduled time of treatment are needed or if the opening of the Center has been delayed. Families may reschedule treatment if they do not wish to travel in poor weather conditions. I understand that if treatment time falls on a holiday that I am encouraged to make up these sessions.
- I understand that if our therapist is ill or on vacation, the Center will provide a substitute therapist to ensure continuation of services. The Center will make every effort to schedule the therapist at your regularly scheduled appointment time. If this cannot occur, the Center will provide an alternate appointment time.

ABA Therapy Scheduling Policy and Consent to Treat

- I hereby consent to treatment services and understand that once a treatment schedule has been established, the Academy may not be able to accommodate short term scheduling changes. Late arrival for an appointment may result in a shorter treatment or cancellation of the treatment and/or change in technician. See Attendance Policy.
- I understand that the Academy is open from 9 a.m. to 4 p.m. Monday through Friday. During times of severe weather, it is my responsibility to call the Academy to determine whether changes in the scheduled time of treatment are needed or if the opening of the Academy has been delayed. The Academy will monitor the weather conditions. I understand that if our technician is ill or on vacation, the Academy will provide a substitute technician to ensure continuation of services.

Teaching and Education of Students

- I give permission for behavioral, occupational, physical, and speech therapy students to observe the patient's therapy.
- I understand that I will be notified before such observation takes place.
- I give permission for 24 hour video surveillance to be taken of myself, or my child for therapeutic and educational purposes.
- I give permission for photographs to be taken of myself, or child for therapeutic and educational purposes

ABA Withdrawal from Program

- If you wish to withdraw from the program a 30 day written notice must be given to the Director.

The undersigned certifies that they have read the foregoing, received a copy thereof, agree to abide by and is the patient or patient's legal guardian to execute the above and accept its terms.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Cole Health
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Financial Responsibility

Patient Name:	**ID:**

In consideration of services rendered or to be rendered to the patient, the undersigned, hereby obligates himself/herself individually and agrees to pay for any and all charges incurred for behavior treatment services. It is agreed and understood that regardless of any and all assigned benefits/monies, I, as the designated responsible party, am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to Cole Health, and agree to pay for any and all charges and expenses incurred. I also understand that as the financially responsible party, I am accountable for the remaining balance not covered by the insurance company. I understand that I am declining my right to do a predetermination of benefits, unless noted below. Predetermination of benefits usually takes from 45 to 60 days before we know if the insurance company will cover treatment services, treatment spots may not be held during this time. In some cases doing a predetermination of benefits is not applicable and is not a guarantee of payment from the insurance company. I understand that Cole Health will work as quickly and efficiently as possible with my insurance provider; however, I will be financially liable for all services not covered by my health plan.

It is further agreed and understood that should this account become delinquent and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit, I as the designated responsible party, shall pay all therapy charges, reasonable attorney's fees, and collection expenses. I understand that at $25 fee will be incurred on each returned check. If I do not call before my appointment to cancel/reschedule, I understand that I could be charged, when applicable, and will incur an unexcused absence.

Assignment of Benefits to Clinician
In consideration of behavior treatment services rendered, I hereby assign and transfer to Cole Health all right, title, and interest in all benefits/monies payable for treatment services by my group medical coverage. It is hereby agreed and understood that any condition precedent, subsequent or otherwise, including, but not limited to, preauthorization, or predetermination shall remain the sole responsibility of client's designated responsible party. I further understand that failure to pre-certify could result in reduced payments from client's insurance co., leaving the undersigned financially responsible for the non-reimbursed portion of patient's bill.

Authorization to Appeal
I hereby authorize Cole Health to appeal on behalf of the patient's claim(s) with my insurance company, if applicable, and/or payer which denies and/or delays payments of my claim(s).

Payment for Services Agreement (This does not apply to clients with Medicaid)
I hereby agree to submit payments in full, unless otherwise agreed upon and noted below. I understand that statements will be sent out by Cole Health at the end of each month, and I agree to remit payment no later than the 1st of each month. I understand that my co-payments or coinsurance must be prepaid a month in advance. I understand that co-payments will be made even during the time that I am paying down my deductible, and that Cole Health will send me a statement at the end of the month with the remaining balance. I understand that Cole Health will be filing the insurance claim forms in my behalf and that I may contact with Cole Health at 281-379-4373 if I have any questions regarding my bill or insurance reimbursement.

When filing with your insurance company, Cole Health will review our current rates with you. If we do not use your insurance and you pay at the time of service, cash pay rates are available. Co-treatments (i.e., treatments with 2 or more therapy professionals involved in therapy) are billed separately. *Rates are subject to change with notification.

*Rates are subject to change with notification.

I understand that I must call Cole Health at 281-379-4373 before the initial assessment to get the insurance information in order. Any changes in insurance policies or companies must be immediately reported to Cole Health. Failure to notify Cole Health of any changes may result in disruption of therapy services or parental responsibility for payment

The undersigned certifies that they have read the foregoing, received a copy thereof, agrees to be bound to the terms and fees within and is the patient or patient's legal representative to execute the above and accept its term.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

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HIPAA Compliance

Patient Name:	**ID:**

I understand that as part of the provision of healthcare services, Cole Health creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change their Notice and practices prior to implementation and will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting, or arranging for medical review, legal services, and auditing functions, etc.). The organization is not required to agree to the restrictions requested.

By signing this form, I consent and authorize clinicians with Cole Health to disclose treatment records, assessment reports, progress notes and any other information necessary to the patient's school, physician, behavioral therapist and/or any other person or entity that would assist in behavior therapy program, payment, and health care operation. I have the right to revoke this consent, in writing, except where disclosures have already been made on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have had the right to request that the use of my Protected Health Information, which is used or disclosed for purposes of treatment, payment, or health care operations, be restricted. I also understand that the Practice and I must agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information, which have been previously agreed upon.

Can we contact other family members or other individuals about the patient's general information & diagnosis?	☐ Yes	☐ No

If yes, please list whom we may inform about the patient's general information and diagnosis (including treatment, payment and health care operations):

Can we contact family members or other individuals about the patient's medical condition only in an emergency?	☐ Yes	☐ No

If yes, please list name, relationship, and phone number:

Name:	Relationship:	Phone Number:

The undersigned certifies that they have read the foregoing, received a copy thereof, and is the patient or patient's legal representative to execute the above and accept its terms.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Child Release

Patient Name:	**ID:**

Emergency Contact and Authorization/Consent for Transportation of Child by Others

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child, if I cannot be reached; I understand that the emergency contacts (listed below) will be called. However, I hereby authorize Cole Health to call an ambulance to transport my child to a hospital or medical facility and to secure for my child the necessary medical treatment. Payment for emergency services will be the responsibility of the parent(s)/ legal guardian(s).

To ensure children's safety, Cole Health will release a child only to the parent(s)/legal guardian(s) who have signed this form and to those listed below as undersigned by the parent(s)/legal guardian(s). Parent(s)/legal guardian(s) who sign the form do not need to be listed on the form. Please include the name of at least one local person who is not your child's parent/legal guardian to whom Cole Health could release your child in an emergency.

Name:								
Relationship:								
Day Phone:								
Evening Phone:								
Address:								
City, State, Zip:								
Emergency Contact:	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Authorized to Transport:	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Date:								
Name:								
Relationship:								
Day Phone:								
Evening Phone:								
Address:								
City, State, Zip:								
Emergency Contact:	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Authorized to Transport:	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Date:								

ABA Therapy:
When picking up your child from car line at Cole Health and you do not have a car seat to transport your child, you will need to sign your child out at the front office. Please review the Texas car seat policy in the link that is provided for you: http://www.txdps.state.tx.us/director_staff/public_information/carseat.html.

By signing this form, I recognize that Cole Health will not release my child to any other person unless I notify the Cole Health in advance, following the guidelines listed below:

- If the person picking up my child is NOT listed on this form, I must notify the Academy in writing.
- Photo identification will be required of any person picking up my child.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Medical Records Obtain/Release

Patient Name:	**ID:**
DOB:	**SSN:**

Authorization to OBTAIN records:
I authorize Cole Health to **OBTAIN** medical record information to include x-rays, reports, clinical lab studies, progress notes and any other pertinent information that would assist in the continuity of medical care and treatment for the patient listed above.

Pediatrician or Primary Care Physician:	
Address:	
Phone Number:	Fax Number:

Other Physician:	
Address:	
Phone Number:	Fax Number:

Authorization to RELEASE records from Cole Health, please allow one week for medical records to be sent to the above named party:

- I authorize Cole Health to **RELEASE** medical record information to include x-rays, reports, clinical lab studies, progress notes and any other pertinent information that would assist in the continuity of medical care and treatment for the patient listed above.
- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for the following: conducting research-related treatment; obtaining information in connection with eligibility or enrollment in a health plan; determining an entity's obligation to pay a claim; or creating health information to provide a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to Cole Health, 16835 Deer Creek Drive Suite 200 Spring, TX. 77379. The revocation will take effect when Cole Health receives it, except to the extent that Cole Health or others have already relied on it.
- I am entitled to receive a copy of this authorization.

Expiration of Authorization

- Unless otherwise revoked, this authorization expires _____ (insert applicable date or event). If no date is indicated, this authorization will expire 12 months after the date of signing this form.

Complaints

- Any or all complaints can be directed to the Privacy Officer at Cole Health, 16835 Deer Creek Drive, Suite 200, Spring, TX, 77379

Other:	
Address:	
Phone Number:	Fax Number:

Other:	
Address:	
Phone Number:	Fax Number:
Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Medical issues that may result in Cancellation/Reschedule

Hand washing and practicing Universal Precautions are the best way to prevent the spread of an infection.

Patient Name:	**ID:**
Medical Issue	Cole Health Policy
Appearance of Rash, Wound, or Lesion	• If rash is accompanied by a fever, it is recommended to reschedule the appointment • Gloves must be worn for any skin irritation with drainage and/or red elevated areas • All equipment used in treatment session must be disinfected • Gloves must be worn while working with any open wound that cannot be covered
Fever	• If child has a fever of 100.5 degrees or higher, it is recommended to reschedule the appointment • If the child has a fever between 98.6 and 100.5 but also showing other signs and symptoms of an infection, it is recommended to reschedule the appointment • Child must be fever free for 24 hours prior to returning to Cole Health.
Eye Infections	• If the child has been diagnosed with Conjunctivitis (pink eye) and has not been on antibiotics for 24 hours, it is recommended to reschedule the appointment • All universal precautions must be used by the therapist
Cough, Congestion or Drainage	• If the child shows signs of a productive cough or runny nose (accompanied with yellow/green mucous and a fever) and it is within the first 48 hours of antibiotics, it is recommended to reschedule the appointment
Lice	• If the child currently has lice (live bugs or nits), it is recommended to reschedule the appointment for when the lice has been adequately removed
Vomiting	• Multiple episodes within the last 24 hours
Diarrhea	• More than 3 episodes in a 24 hour period
Diseases	• Strep Throat, mononucleosis, chicken pox, influenza, measles, rubella, bacterial meningitis, mumps, whooping cough, scarlet fever, and Tuberculosis.

Should a child be sent home due to illness, they will need to be picked up (from ABA Therapy) within 1 hour of being contacted to avoid any additional fees.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Attendance Policy (Physical, Occupational, Speech Therapy)

Patient Name:	**ID:**

- Please arrive early for your scheduled appointments. If you think you may be late please contact the office to let them know.
- We encourage you to not leave the premises, if you must please provide a working phone number.
- If you need to reschedule an appointment, you must do so AT LEAST 2 hours BEFORE the scheduled appointment time. A cancellation of less than 2 hours of the appointment time will be considered a No Show.
- No shows are when you fail to call to cancel and/or do not show up to the appointment, or if you cancel within 2 hours prior to the appointment time. These missed appointments still need to be rescheduled.
- Excessive absences and No Shows can prevent progress for the child, as all children do better with consistency! Absences may also result in therapy sessions not being covered by insurance or Medicaid.
- Attendance rate should remain above 90% to avoid being discharged.
- If there are more than 4 missed appointments or 2 no shows within a 60 day period, Cole retains the right to discharge the patient due to non-compliance with attendance. Your child's primary care physician will be notified.
- If you know you are going to be out of town, please let us know as soon as possible so that any missed sessions can be rescheduled ahead of time.

Sick Policies

- If you or your child is sick, please reschedule your appointment as soon as you know. (The 2 hour cancellation policy also applies for illness). We ask that you not to bring a child to therapy until they have been fever FREE for at least 24 hours. This will prevent spreading of the illness to other children.
- If you are unsure whether your child should be seen for therapy, please contact the office right away.

Rescheduling Appointments

- If the child's appointment is cancelled (whether cancelled by the caregiver or clinician), the missed sessions should be rescheduled.
- If the therapist is ill or out of office, we will attempt to reschedule your appointment with another clinician during the regular appointment time. If this is not possible, an alternate appointment time will be offered.
- Make-up appointments are not guaranteed to be with the regular treating therapist.

Permanent Schedule Changes

In order to maintain consistency and progress with your child, we strongly discourage frequent schedule changes. We will accommodate **1** permanent schedule change in a six month period. **Saturday/Sunday Appointments** Due to a growing need on Saturdays/Sundays, it would not be fair to hold open appointments for patients who do not show or frequently cancel. Therefore, Cole Health's policy for Saturday/Sunday appointments is: A patient may be removed from the Saturday/Sunday schedule if (1) "No Show" occurs however, your child is allowed 1 cancellation per 3 month period.

Telehealth

Speech, Occupational, and Physical Therapy may also be available through Telehealth, depending on your payer source. Telehealth is innovative online therapy that is customized to meet the needs of your child. Please talk to your Case Manager if this is something you are interested in.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Attendance Policy (ABA Therapy)

Patient Name:	**ID:**

Our greatest desire is to deliver our patients the highest level of care available in order to maximize the benefits of treatment. Consistent attendance demonstrates patient commitment and leads to better potential for patient progress. With your help this can be accomplished.

Our payer sources require progress notes as part of the review process for authorization of payment for treatment. All absences are noted and require a reason for the cancellation to be noted. Excused absences include patient illness with doctor's note. Extenuating circumstances of absences will be considered. Numerous absences or no shows may result in treatment not being covered by insurance. If the patient will be late for therapy, caregivers are expected to call the clinic as soon as possible with a time the child will be arriving. If no time is given, the scheduled therapist will be sent home at 9:30 am and the session will be cancelled for the day, resulting in an unexcused absence. If a time is given, and the child does not arrive to therapy within 10 minutes of the given time, the scheduled therapist will be sent home and the session will be cancelled for the day, resulting in an unexcused absence.

Cole Health will enforce the attendance policy for patients who do not show or fail to cancel a treatment with at least 24 hours prior notice, resulting in an unexcused absence. Your child will be allotted a specific amount of excused hours to use for absent time which can be used for illness, vacations, or at the discretion of parent/guardian. This is in addition to the pre-scheduled Cole Holiday closures. Notifications of vacations or family obligations are requested at least two weeks prior to the expected absence. For a full time patient receiving 35 hours per week, your child may use 105 excused hours maximum from January 1st through December 31st of each calendar year. For a part time patient receiving 20 hours per week, your child may use 60 excused hours maximum from January 1st through December 31st of each calendar year. Hours are prorated for families whose children are admitted in the middle of the calendar year.

After these excused hours are exhausted, the parent/guardian is responsible for paying any fees associated with absences. Individuals will be charged a cancellation fee of $25 per day for any absences exceeding the allotted maximum hours. 2 unexcused absences will be granted. After 2 unexcused absences, a $25 cancellation fee will be charged per day for any unexcused absence.

All fees owed by the patient are due in advance by the 1st business day of each month. Refunds will not be given for absences after the invoice had been processed**.** If the patient will be out for an extended amount of time, refunds will be dealt with on a case by case basis.

Excused absence = Patient has given 24 hours or more notice or provides a doctor's note, and the total number of allotted excused hours have not be exhausted.
Unexcused absence= Patient has not given 24 hour notice, has not provided a doctor's note for missed day, and/or the total number of allotted excused hours has been exhausted. 2 instances will be waived before a $25 cancellation fee.

Patients arriving more than 1 hour late or leaving more than 1 hour before dismissal time will be considered absent for the treatment day.

Parents must sign in/sign out their child on the tablet and daily notes, at the time of pick up/ drop off.

Parents must arrive on time to pick up their child. Parents will be given a 5 minute grace period. However, continual or repeated occurrences of late pick-ups beyond the 5 minute grace period will result in a late fee of $5.00 per minute. This fee will also be assessed if the child is sent home due to illness after a 1 hour grace period.

The following days are holidays:
New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, The day after Thanksgiving, The day before Christmas, and Christmas.

The Academy will monitor the weather and notify accordingly.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Supply Fee (ABA Therapy)

Patient Name:	**ID:**

As you may know there are certain tools and supplies that are vital to your child's progress and not covered by insurance.

A monthly supply fee of $35* will enable us to provide the best possible treatment for your child. This monthly fee is NOT covered by any insurance plans and will be due on the 15th of each month.
*If your child maintains a 95% attendance rate for the month, $15 of the supply fee will be waived.

This fee will cover:

-reinforcements
-toys
-books
-and most importantly, the Data Finch/Catalyst Program and the digital devices for use with the Program. These devices are used as reinforcers for the children, communication devices, picture schedules, assessments, teaching material and real time data collection.

As previously mentioned, we are use a program called Catalyst (www.datafinch.com) which was developed with the assistance of a Board Certified Behavior Analysts Coby Lund PHD, BCBA-D and Janet Lund PHD, BCBA-D. It is important to note that Catalyst is HIPPA compliant.

Catalyst has different components: a digital device, where data is collected, and an on-line portal for data storage, notes, program management, graphing and analysis. Via the on-line portal, the BCBA can set specific skill acquisition and behavior reduction targets, view real-time graphs with data and even produce reports on weekly progress. Parents can also review SOAP notes from sessions. The Cole Academy can also use the portal to upload videos of treatment for parents to view. **Parents will be given log-in information so that they can view their child's ongoing data and progress**. The program also allows the BCBA to create detailed reports, including analysis of data, for caregivers or insurance companies in order to get continued treatment for your child.

Thank you for your cooperation as we continue to bring hope and change lives.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Nut Allergy (ABA Therapy)

Cole has decided to become a peanut/nut free facility beginning in 2019.

Allergic reactions (anaphylactic shock) can occur through ingestion of peanut/nut products, cross contamination and breathing peanuts/nuts in the air.

We are asking for your help by:

a) Avoiding sending children peanuts/nuts in lunches
b) Avoiding sending peanut butter sandwiches or other spreads containing nuts such as Nutella, almond butter, etc.
c) Avoiding sending snacks/bars containing nuts or labelled "may contain nut traces"
d) Avoid sending products with peanuts/nuts for events and parties

If your child is on a specific feeding plan which requires peanut/nut products, please speak with the supervising BCBA or Clinic Director about alternative options.

It is important that all parents carry out the suggested measures and reduce the risk of potential allergic reactions. If you have any questions, you may contact our supervising BCBA or Cole Academy at 281-290-4411.

Thank you for your cooperation with our new policy.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Extended Care Policy (ABA Therapy)

Patient Name:	**ID:**

Our greatest desire is to deliver our patients the highest level of care available in order to maximize the benefits of treatment. Cole Academy offers extended care to provide families with a later time to pick up their child.

Extended care is provided from 4:00 pm – 6:00 pm. Rates are charged hourly, at the hour mark; therefore, the full hourly rate will be charged at each hour mark.

Any patient not picked up by 4:00 pm will be sent to aftercare. The parent/guardian is responsible for paying any fees associated with extended care.

Cole Health will enforce the attendance policy for patients who do not show by 6:00 pm.

Parents must arrive on time to pick up their child. Parents will be given a 5 minute grace period. However, continual or repeated occurrences of late pick-ups beyond the 5 minute grace period will result in a late fee of $5.00 per minute.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Scheduling Agreement (ABA Therapy)

Welcome to the Cole Academy! We are excited to begin helping your child reach his or her full potential. Upon starting treatment with Cole Academy, we have provided a behavior therapist to deliver therapy to your child based on an agreed upon schedule. There are limited spots available.

You are agreeing to bring your child to therapy on days as scheduled and recommended by the supervising BCBA. Any additional reoccurring therapies or activities, other than doctor appointments or prescheduled time off, will be scheduled outside of these hours. You have previously signed the attendance policy and understand that your child should maintain an 85% attendance rate on the scheduled days as listed above or there is a chance that your child may be discharged.

If you are interested in altering scheduled therapy days, days will be altered as therapists are available to accommodate those changes. If accommodation to the schedule is not possible, you will be given alternate available days, or your child may be placed on the wait list until a spot becomes available with your requested hours.

Please remember that ABA therapy is medically necessary. Attending the recommended number of therapy hours are necessary to ensure treatment effects and to promote progress based on your child's specific needs.

By signing below, you are agreeing to attend the scheduled treatment hours and understand that future modification of these hours may not be possible and could lead to your child being placed on the wait list or discharged from treatment.

Signature of Parent or Legal Guardian and relationship	Date
Witness	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Credit Card Authorization Form

Cardholder Name: _____

Billing Address: _____

City _____ State _____ Zip _____

Mastercard _____ Visa _____ Amex _____ Other _____

Card number _____ Expiration date _____

CVV code _____ Payment amount _____

Patient Name _____ Patient DOB _____

I, _____, authorize Cole Health to charge the credit card above for agreed upon services. I understand that my information will be kept on file to process future transactions for services rendered.

I understand that Cole Health will charge my card on or before the 15th of each month for any outstanding balances unless otherwise notified. Cole Health must be notified of any changes to the method of payment.

_____

Cardholder Signature

_____

Date