



Client Registration		
Client Name	Pronouns	Date of Birth
Primary Language in the Home	Client Primary Mode of Communication/Language	Age
Address	City, State, Zip	
Lives with	Primary Contact Person	
Diagnosis	Funding Type	
Date of Diagnosis	Who Diagnosed	
How Did You Hear of Us?		
Guardian Information		
Guardian Name	Relationship	
Address	City, State, Zip	
Phone Number	Email	
Guardian Occupation	Pronouns	
Guardian Name	Relationship	
Address	City, State, Zip	
Phone Number	Email	
Guardian Occupation	Pronouns	
Communication Preference		
Educational Information		
School or Day Treatment Name	Type of Placement	
Grade (if applicable)	IEP or Behavior plan in place?	
Primary Insurance Information		
Primary Insurance Company	Subscriber's Name	Date of Birth



Address		City, State, Zip	
Group #	Member Policy #	Effective Date	Relationship to Client
Employer Name		Fully-funded or Self-funded?	

Secondary Insurance Information				
Secondary Insurance Company		Subscriber's Name		Date of Birth
Address		City, State, Zip		
Group #	Member Policy #	Effective Date	Relationship to Client	
Employer Name			Fully-funded or Self-funded?	

I certify that the information provided by me is correct	<b>Authorization to Release Information</b>	
	I authorize PRECISION ABA, LLC. to release to my insurance carrier or its designated agents any information concerning medical care, advice, treatment, or supplies provided to me for the purpose of administration, review, investigation, or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify PRECISION ABA in writing of any information I do not want released.	
	Signature	Date

<b>Assignment of Benefits</b>
I authorize the assignment of benefits payable to PRECISION ABA and/or its designee for services and supplies. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

<b>Authorization of Additional Fees</b>
In the event of any lawsuit of action is brought to collect this account or any portion thereof, parent or guardian will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest and any additional cost that this action may incur.

<b>Authorization for Treatment</b>
Precision ABA's team is not responsible for administering any emergency or medical interventions including first aid for your child when sessions occur in the presence of a parent or responsible adult in the home. If a situation arises, the responsible adult in the home will be alerted to take action.
If your child's sessions are taking place in our center, a person trained in first aid and medical interventions will take action on your child's needs. If a situation arises that required more than basic first aid, an ambulance will be called and parents/guardians will be alerted immediately. In the event that the parents/guardians do not get in contact with Precision ABA, the emergency contact listed above will be alerted immediately.

Signature	Date
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<b>Reason for Referral for ABA services</b>
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## Areas of Strength

## Areas of Difficulty

## Likes

## Goals

## Additional Information

Sleep Disturbances?

Eating Concerns?

Other Providers Currently Providing Treatment? (e.g., Speech, OT, Neurologist)