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	Pronouns	Relationship
Address	City, State, Zip	
Phone Number	Email	
Guardian Occupation	Employer	
Guardian Name	Pronouns	Relationship
Address	City, State, Zip	
Phone Number	Email	
Guardian Occupation	Employer	
Communication Preference	My child is vaccinated in alignment with CDC Child and Adolescent Immunization Schedule (initial)	

Educational Information

School or Day Treatment Name	Type of Placement
Grade (if applicable)	IEP and/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?	

Authorization to Release Information

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

Assignment of Benefits

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. I understand that I must disclose all insurance policies my child has to Precision ABA.

Authorization of Additional Fees

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.

Authorization for Treatment

I agree to have my child participate in Applied Behavior Analysis (ABA) assessment and/or treatment services provided by PRECISION ABA. I understand that the specific activities, goals, and desired outcomes of these ABA services will be fully discussed with me, and that I will have the opportunity to ask for clarification prior to services being rendered. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation. I also understand that my child is the primary client of the behavior analyst and that services will be designed primarily for my child's benefit. Any other individuals or agencies (e.g., siblings, family, day-care providers) who may be affected by the ABA services are considered secondary clients. I assert that I am my child's legal guardian and have legal decision-making rights. I certify that the information provided above is correct.

Signature	Date

Precision ABA
Helping Children Grow to New Heights

Reason for Referral for ABA services

Areas of Strength

Areas of Difficulty

Likes

Goals

Additional Information	
Sleep Disturbances?	Eating Concerns?
Other Providers Currently Providing Treatment? (e.g., Speech, OT, Neurologist)	