ABA INSIGHT

INSPIRING SUCCESS

New Client Intake Forms

Child's Name: (First, Middle, Last)	Child's Date of Birth _ _/ _ _ / _ _ _ _	Gender	
Address 1	City	State	Zip Code
Address 2	County	Country	
School Name	School Phone	SSN	
Father/Guardian's Name	Legal Guardian?	Primary Guardian?	
Address 1		Home Phone	
Address 2		Cell Phone	
City	State	Zip Code	
Employer		Work Phone	
Mother/Guardian's Name	Legal Guardian?	Primary Guardian?	
Address 1		Home Phone	
Address 2		Cell Phone	
City	State	Zip Code	
Employer		Work Phone	
Any relevant legal issues? If yes, please explain:			

Emergency Contacts

List 3 individuals, including parents/legal guardians in order of preference to be contacted in the event of an emergency. If possible, include at least one person other than the parents/legal guardians.

1.	( )	☐ Text ☐ Call
2.	( )	☐ Text ☐ Call
3.	( )	☐ Text ☐ Call

Medical Information	
Name of Child's Primary Care Physician:	Physician Phone:
Preferred Hospital for Emergency Treatment:	
Is your child taking any prescribed medications and/or supplements? ☐ Yes ☐ No	

Medication:	Dosage:	Frequency:

Allergies:

Dietary Restrictions
☐ Gluten Free ☐ Soy Allergy ☐ Organic Only ☐ Casein Free ☐ Vegetarian ☐ Diabetic ☐ Metabolic Disorder ☐ Egg Allergy ☐ No Red Dye ☐ Lactose Intolerant ☐ No Sugar ☐ Peanut Allergy ☐ Other:

Clinical Diagnoses Please list all diagnoses given by medical providers along with dates of diagnoses.

Immunizations	
Has your child been immunized? ☐ Yes ☐ No If yes, check all that apply:	
☐ Hepatitis B ☐ Rotavirus ☐ DTap (<7 yrs Diphtheria, Tetanus, Whooping Cough) ☐ Tdap (>7 yrs Diphtheria, Tetanus, Whooping Cough) ☐ Hib (Haemophilus Influenzae) ☐ PCV13 (Pneumococcal conjugate)	☐ IPV (Inactivated Poliovirus) ☐ IVV; LAIV (Influenza) ☐ MMR (Measles, Mumps, Rubella) ☐ VAR (Varicella) ☐ Hepatitis A ☐ HPV (>11 yrs Human Papillomavirus) ☐ Meningococcal (>11 yrs)

Medical History Check all items that your child has or has had in the past.		
☐ Skin Rash	☐ Sore Teeth	☐ Headaches
☐ Ear Infections	☐ Diabetes	☐ Epilepsy
☐ Eczema	☐ Brain Tumor	☐ Fainting/Dizziness
☐ Anxiety	☐ Depression	☐ Mania
☐ Allergies (food)	☐ Allergies (environmental)	☐ Vision Problems
☐ Sinus Problems	☐ Heart Problems	☐ Cerebral Palsy
☐ Kidney Problems	☐ Bruises Easily	☐ Low Blood Sugar
☐ Arthritis	☐ Hypertension	☐ Low Blood Pressure
☐ Asthma	☐ Thyroid Problems	☐ Chronic UTI
☐ Encopresis	☐ GI Problems	☐ Liver Disease
☐ Acid Reflux	☐ Ulcers	☐ Tremors
☐ Sleep Apnea	☐ Latex Allergy	☐ Irritability
☐ Enuresis	☐ PMS	☐ Psychiatric Care

Please explain any items that were marked above:

Are regular blood levels drawn? ☐ Yes ☐ No If yes, what are the levels for?

Has your child been diagnosed with a particular syndrome or genetic disorder?

Does your child have a history of abuse, trauma, or sexual behavior? If yes please explain:

Family Medical History

Check all items that someone in the child's immediate family (parent or sibling) has or has had in the past.

☐ Skin Rash	☐ Sore Teeth	☐ Headaches
☐ Ear Infections	☐ Diabetes	☐ Epilepsy
☐ Eczema	☐ Brain Tumor	☐ Fainting/Dizziness
☐ Anxiety	☐ Depression	☐ Mania
☐ Allergies (food)	☐ Allergies (environmental)	☐ Vision Problems
☐ Sinus Problems	☐ Heart Problems	☐ Cerebral Palsy
☐ Kidney Problems	☐ Bruises Easily	☐ Low Blood Sugar
☐ Arthritis	☐ Hypertension	☐ Low Blood Pressure
☐ Asthma	☐ Thyroid Problems	☐ Chronic UTI
☐ Encopresis	☐ GI Problems	☐ Liver Disease
☐ Acid Reflux	☐ Ulcers	☐ Tremors
☐ Sleep Apnea	☐ Latex Allergy	☐ Irritability
☐ Enuresis	☐ PMS	☐ Psychiatric Care

Developmental History

Please describe any prenatal or perinatal events with your child's birth:

Please describe your child's development and when/if they reached the following milestones:

Rolling Over:

Babbling:

Crawling:

Walking:

Talking:

Other:

Medical Treatment History

Please list any relevant historical and current medical treatments, providers, and your child's response to these:

Therapy History

Please list any relevant historical and current therapies, providers, and your child's response to these:

ABA Therapy History

Please list any relevant historical and current ABA therapies, providers, and your child's response to types of interventions:

Communication

How does your child communicate? (Please check all that apply)

☐ Aggression ☐ Crying ☐ Gestures ☐ Pictures ☐ Pushing/Pulling Away ☐ Sign ☐ Verbal

Does your child?

Make spontaneous requests	☐ Yes ☐ No	Respond to "What do you want?"	☐ Yes ☐ No
Make spontaneous comments	☐ Yes ☐ No	Understand "wait"	☐ Yes ☐ No
Respond to questions	☐ Yes ☐ No	Follow one-step instructions	☐ Yes ☐ No
Respond to comments	☐ Yes ☐ No	Follow multi-step instructions	☐ Yes ☐ No
Imitate/Echo	☐ Yes ☐ No	Follow a schedule	☐ Yes ☐ No
Request reinforcers	☐ Yes ☐ No	Answer questions	☐ Yes ☐ No
Ask for help	☐ Yes ☐ No	Respond to "No"	☐ Yes ☐ No
Ask for a break	☐ Yes ☐ No	Indicate yes/no	☐ Yes ☐ No

At home, we currently utilize the following augmentative communication tools:

☐ Electronic Talkers ☐ iPad ☐ PECS ☐ Picture Schedules ☐ Sign

Behavior

I have observed the following behaviors from my child: (Please check all that apply)

☐ Kicking	☐ Tantrums	☐ Public Masturbation
☐ Hitting	☐ Repetitious/Compulsive	☐ Rectal Digging
☐ Biting	☐ Feces Smearing	☐ Eloping
☐ Mouthing	☐ Hair Pulling	☐ Lying
☐ Climbing	☐ Spitting	☐ Property Destruction
☐ Screaming	☐ Covers Ears	☐ Scratching
☐ Head Banging	☐ Swearing	☐ Pacing
☐ Skin Picking	☐ Grinding Teeth	☐ Inappropriate
☐ Other:		

Please list what you want to see your child doing in the next 6 months-year:

Toilet Training

Are you currently trying to toilet train your child? ☐ Yes ☐ No

If no, please explain:

If yes, please answer the following questions:

Are you currently working on urination, bowel movements, or both?

What toilet training methods are you currently using?

What toilet training methods have you tried in the past?

Are you interested in having your child address potty training? ☐ Yes ☐ No

What does your child currently wear? ☐ Diaper ☐ Pull-Up ☐ Underwear

If diaper or pull-up, how often is he/she changed during awake hours?

Does your child stay dry at night? ☐ Yes ☐ No

Does your child initiate using the toilet? ☐ Yes ☐ No

Is he/she able to sit on the toilet for 10 minutes at a time? ☐ Yes ☐ No

Does your child sit or stand for urination? ☐ Sit ☐ Stand ☐ Unsure

Does your child use a special toilet seat or chair? ☐ Yes, explain ☐ No

Can your child pull their own pants down?

Can your child pull their pants up?

What is his/her success rate? (e.g. 1 out of 5 tries):

How resistant is he/she to learning to use the toilet?

Do any behaviors occur when your child is asked to use the toilet? ☐ Yes ☐ No
If yes, please describe the behaviors that occur:

Does your child attend school? ☐ Yes ☐ No
If yes, would school implement our recommended toilet training protocol? ☐ Yes ☐ No

Any additional information:

Sensory Processing	
General Indicators of Sensory Processing Difficulties: (Check all that apply)	
☐ Hypersensitive to sensory input ☐ Perseverative behaviors (can't let go of ideas) ☐ Poor planning and organization of behavior ☐ Low frustration tolerance/angered easily	☐ Upset by change ☐ Overly aroused or overly passive ☐ Hyposensitive to sensory input (clumsy/doesn't seem to 'get it' or 'catch on')
Comments:	
Does your child… ☐ Express discomfort when performing daily routines and grooming tasks (fights or cries during diapering, dressing, hair cutting, face washing, bath time, nail cutting)	

- ☐ Appear to be irritable – upset or crying most of the time, impossible to comfort
- ☐ Become anxious or distressed when feet leave the ground
- ☐ React emotionally or aggressively to touch
- ☐ Have difficulties during mealtime (resists certain food textures/smells, difficulties chewing/swallowing)
- ☐ Display excessive drooling – beyond teething stage
- ☐ Have sleep problems – requires extensive help to fall asleep or wake up
- ☐ Lack of exploratory behavior/doesn't notice when face or hands are messy
- ☐ Seek an unusual amount of proprioceptive input through rough tumble and play
- ☐ Insist on unusual routines or strategies associated with play or personal care
- ☐ Become overly excitable during movement activities
- ☐ Tires easily or seem to have weak muscles
- ☐ Respond negatively to loud or unexpected noises
- ☐ Other:

Does your teenager/adult…

- ☐ Appear to not like being touched
- ☐ Avoid visually stimulating environments and/or sensitive to sound
- ☐ Often seem lethargic and slow to begin day
- ☐ Always seems to be "on guard" or has difficulty relaxing
- ☐ Use inappropriate force when handling objects
- ☐ Bump into objects in environment often or appear clumsy
- ☐ Explosive emotions
- ☐ Require physical activity to maintain focus throughout the day
- ☐ Difficulty learning new motor tasks, or sequencing steps of a task
- ☐ Avoids certain food textures or smells
- ☐ Difficulty transitioning between activities, places, events, etc.
- ☐ Jumps from one activity to another, does not finish task or activity at hand
- ☐ Other:

Reinforcers

Reinforcers are items that your child particularly likes that can be used to motivate or reward appropriate responses/interactions. Please check all that apply in each of the following categories.

Activities

☐ Building (blocks)	☐ Movies	☐ Running	☐ Tickles
☐ Cards	☐ Music	☐ Sandbox	☐ Trampoline
☐ Climbing	☐ Painting	☐ Shredding	☐ Turn Taking Games
☐ Coloring	☐ Pounding	☐ Singing	☐ Twister
☐ Dancing	☐ Pouring	☐ Sweeping	☐ Walking

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☐ Drawing	☐ Rocking	☐ Swinging	☐ Other:
☐ Memory Games			
Community Activities			
☐ Bike Rides	☐ Library	☐ Museums	☐ Recycling
☐ Bookstore	☐ Mall	☐ Parks	☐ Recreation Centers
☐ Burger King	☐ Music	☐ Parties	☐ Water Parks
☐ Concerts	☐ McDonalds	☐ Pet Stores	☐ Other:
	☐ Movies		
Food			
☐ Animal Crackers	☐ Doritos	☐ Milk	☐ Raspberries
☐ Apple Juice	☐ Dum-Dum Suckers	☐ Mixed Nuts	☐ Rice Cakes
☐ Apples	☐ French Fries	☐ Mountain Dew	☐ Root Beer
☐ Applesauce	☐ Gatorade	☐ Orange Juice	☐ Skittles
☐ Bananas	☐ Ginger Ale	☐ Oranges	☐ Sprite
☐ Broccoli	☐ Granola Bars	☐ Pancakes	☐ Starbursts
☐ Carrots	☐ Grape Juice	☐ Peanut Butter	☐ Strawberries
☐ Celery	☐ Grapes	☐ Peanuts	☐ Tomatoes
☐ Cheez-Its	☐ Gum	☐ Peppermint Candy	☐ Triscuits
☐ Chicken Nuggets	☐ Gummy Candy	☐ Popsicles	☐ Waffles
☐ Coke	☐ Hamburger	☐ Pork Rinds	☐ Walnuts
☐ Chex Mix	☐ Kool-Aid	☐ Potato Chips	☐ Water
☐ Crackers	☐ Lifesavers	☐ Pretzels	☐ Yogurt
☐ Diet Coke	☐ M&M's	☐ Pudding	☐ Other:
Toys			
☐ Action Figures	☐ Chalk	☐ Mr. Potato Head	☐ Slinky
☐ Airplanes	☐ Computer	☐ Noise Makers	☐ Spin Toys
☐ Animals	☐ Dolls	☐ Oral/Mouth Toys	☐ Sports Equipment
☐ Barbie	☐ Forts	☐ Paint	☐ Squeeze Toys
☐ Beads	☐ Hotwheels	☐ Play-Doh	☐ Stickers
☐ Blocks	☐ Interactive Toys	☐ Pop Up Toys	☐ Stuffed Animals
☐ Boats	☐ Kitchen Toys	☐ Push Toys	☐ Tools
☐ Boom Sticks	☐ Lawn Toys	☐ Puzzles	☐ Velcro
☐ Bouncy Balls	☐ Legos	☐ Sand Toys	☐ Vibrating Toys
☐ Bubble Wrap	☐ Lincoln Logs	☐ Shape Sorters	☐ Other:
☐ Bubbles			
Television/Movies			
☐ Aladdin	☐ Diego	☐ Incredibles	☐ Mulan
☐ Baby Einstein	☐ Donald Duck	☐ Land Before Time	☐ Shrek
☐ Backyardigans	☐ Dora the Explorer	☐ Lilo and Stitch	☐ Sleeping Beauty

☐ Barney	☐ Electric Company	☐ Lion King	☐ Snow White
☐ Beauty & the Beast	☐ Elmo	☐ Little Mermaid	☐ Spongebob
☐ Bert	☐ Ernie	☐ Madagascar	☐ Toy Story
☐ Big Bird	☐ Finding Nemo	☐ Megamind	☐ Up
☐ Bob the Builder	☐ Goofy	☐ Mickey Mouse	☐ Wall-E
☐ Bug's Life	☐ Grover	☐ Minnie Mouse	☐ Other:
☐ Cars	☐ Hercules	☐ Monsters Inc.	
☐ Cookie Monster	☐ iCarly	☐ Mr. Rogers	

Other

☐ Books ☐ CDs/DVDs ☐ Computer ☐ iPad ☐ Pens/Markers ☐ Pictures ☐ Remotes
☐ Other:

Additional Testing/Services

Has the parent/guardian completed the Vineland Adaptive Behavior Scale? ☐ Yes ☐ No ☐Attached

If yes, list the date of the most recent Vineland interview:

Has the child had an ADOS or AAEC Diagnostic Evaluation?	☐ Yes	☐ No	☐ Attached
Does the child have a behavior plan?	☐ Yes	☐ No	☐ Attached
Does the child have an occupational therapy plan?	☐ Yes	☐ No	☐ Attached
Does the child have a current physical?	☐ Yes	☐ No	☐ Attached
Does the child have a speech plan?	☐ Yes	☐ No	☐ Attached
Does the child have an IEP or 504 plan?	☐ Yes	☐ No	☐ Attached

Does your child receive any additional therapies or services? If so please describe below:

Patient Name:	Date of Birth:
Parent or Legal Guardian:	

Please indicate below that you have received either the Center or In-Home Clinical Manual:
☐ I have received the Center Clinical Manual
☐ I have received the In-Home Clinical Manual

Please initial the following, indicating that you have received and agree to the policies below taken from the manuals.

I as the patient, parent, or legal guardian consent or agree to the following (initial next to all that apply):

___ **Consent to Evaluate and Treat:** The patient above is being treated by ABA Insight, LLC., and I consent to all behavioral health assessments and treatment as determined by supervising clinicians. I understand I have the right to decline services and testing, and I assume full responsibility and release ABA Insight, LLC. and the clinicians relating to services and testing for which I decline. I do however, understand that financial assistance is available if I should need it. I know that the practice of behavioral health is not an exact science and outcomes may be different for each patient.

___ **Notice of Privacy Practices:** I agree I have received or been offered a copy of ABA Insight's Notice of Privacy Practices which provides information on how ABA Insight, LLC. may use or disclose PHI. I have been given an opportunity to opt-out of certain uses or disclosures of the patient's PHI if I choose to by completing the opt-out form.

___ **Authorization to Share Information:** I understand that ABA Insight, LLC. may collaborate with other healthcare, behavioral health, and social service providers to coordinate, manage, and provide treatment to the patient. I consent to ABA Insight, LLC. sharing my health information and records electronically for the purpose of treatment, payment, or operations including eligibility verification, insurance payers, state and federal programs, Workers' Compensation, quality improvement, compliance and health care oversight activities, and other agencies as needed. This collaboration improves the overall quality of care services to the patient.

___ **Missed Appointment Policy:** I acknowledge receipt of ABA Insight's Missed Appointment Policy and agree to notify the office and/or clinicians as soon as possible if unable to keep the scheduled appointment time.

___ **Patient Financial Obligation:** I agree I have received or been offered a copy of ABA Insight's Patient Financial Obligation Policy. I understand that I am financially responsible for charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to the patient which are not eligible for payment (non-covered, i.e. co-insurance, deductible, copay, etc.).

___ **Video and Marketing Authorization:** I have read and understand ABA Insight's Video and Marketing policy, and have indicated my authorization or lack there of on the attached consent form.

- **Consent for Emergency Medical Attention:** In the event that I cannot be reached to make arrangements for emergency medical care, I authorize ABA Insight to take my child to the emergency facility as indicated in the intake paperwork.

- **Confidentiality Agreement:** All patients and families of Insight Center have the right to patient confidentiality. Therefore, all visitors/volunteers are required to ensure the privacy of patients and families receiving services at Insight. I agree to adhere to the above policy and preserve the privacy of all Insight patients and families. I will not divulge any specific patient information, including names, etc. unless given written permission from the patient/family to do so. If I violate this policy, I understand that Insight is not liable for any actions brought against me by patient and/or family.

- **Resolution Request:** This form is intended to be used to facilitate the expeditious and amicable resolution of disagreement, concerns or other issues raised internally. Should concerns arise, please use this form included in the Clinical Manual.

Patient Name:	
Parent or Legal Guardian Signature:	Date Signed:

Authorization for Sharing Information

THINGS YOU SHOULD KNOW (PRIVACY NOTICES):

a. You should know that if using a patient's health insurance plan for services, ABA Insight and the insurance company may share your information to the policy holder/parent for services you receive. In addition, if you agree to use your parent's/spouses' health insurance, they would receive a bill and would have access to your diagnosis.

b. Understand that the consent will be in effect until you withdraw it in writing or for the period specifically listed here __________________. Further, you should understand that you may opt out of this type of release of information by providing writing notice to your clinician. You have to tell us in writing if you want to change anything.

c. If you give permission to share your health insurance with another person, that person could re-disclose your health information and your information is no longer protected by Federal privacy regulations.

This is where you (the patient) fill in your information:		
Patient Name (Last/First/Middle Initial):		Date of Birth:
Address:		
City:	State:	Zip:
Contact Phone Numbers:		
Email:		

This is where you fill in who you are allowing to get your information:		
Name:		
Address:		
City:	State:	Zip:
Phone Numbers:	Relationship:	

Name:		
Address:		
City:	State:	Zip:
Phone Numbers:	Relationship:	

This is where you decide if you authorize ABA Insight to share your information as listed below:

I agree/decline to share the following information:

- ☐ I agree to share/release all relevant information, including release of all the following:
- ☐ I agree to share/release ONLY the specific information listed:
- ☐ I decline to share/release my health information

Signature of Patient or Legal Guardian	Date

Consent to Evaluate and Treat
Acknowledgement of Notice of Privacy Practices

I, the undersigned, am the Parent or true and legal guardian of the above named patient or for whom I have legal guardianship, and I authorize ABA Insight to perform evaluations and/or treatment services as necessary and appropriate given the patient's diagnosis, abilities, skills and goals discussed and developed by the patient's planning team.

I understand that Insight may be a training site for students and that qualified Insight staff will supervise students. Such training may be involved with me and/or my child at Insight. I understand that Insight may use or disclose any and all information about me and/or my child for its use in its training program and as allowed by law.

I understand that I must and do give my consent to Insight to arrange for emergency medical treatment for the above named patient in case of an emergency. I understand that federal law permits Insight to release any protected health information necessary about the above named patient for any such emergency treatment.

I release Insight, its employees, staff, agents and volunteers for any and all liability, claims, or suits, which may arise from the above named patient's participation in the program provided by this agency.

I acknowledge that Insight has provided to me a reviewable copy of the Notice of Privacy Practices and Patient Rights. Theses notices explains how my protected health information is used and disclosed by Insight for treatment, payment, operations, and other uses under Federal HIPAA and other laws. These notices explain my rights regarding my protected health information and what rights I hold as a recipient of Insight services. These are posted in the public areas of Insight. I acknowledge that I have received a copy of the Notice of Privacy Practices and Patient's Rights documents.

Signature of Patient or Legal Guardian	Date

Video and Marketing Authorization

I understand that Insight Center is requesting access to my child's first name, picture, video, other audio visual or sound recording or testimonial of services to be used to monitor, demonstrate, and market Programs. These items may be used by Insight Center acting only on authorization, for the purpose of illustration, broadcast, or testimonial in connection with the work of Insight. These materials may be released to the general public under the conditions below.

I understand that pictures, videos (and other items named above) and my child's name are protected health information (PHI), as defined under 45 C.F.R. 164.501, and as such, are treated confidentially by Insight, their respective employees and agents, and those acting with Insights' permission. This information cannot be released without authorization from the patient/patient's family.

I understand and agree that Insight employees will review with me such material as stated above so that we can together select the appropriate materials for release, however, I understand that these materials made by Insight, its employees and agents are owned by Insight and that they may copyright them.

I understand that these materials may be published on Insights' websites. As a result, selected elements of my child's personal information may be disclosed online however, disclosure will be limited to my child's picture/video or likeness, my child's first name and/or the designation of Insight Center (i.e., "Luke, Insight Center" or just their picture without a first name).

I understand that the rights described above are granted to Insight on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Insight will not condition any treatment or funding to my child on the completion of this authorization. This release will be in effect for (1) one year from the date of the signature below.

I also understand that I may revoke my authorization at any time if the information has not already been disclosed. To revoke my authorization, I must notify Insight in writing.

I understand and agree that once Insight, its respective employees and agents, and those acting with its permission, disclose my child's protected health information, as noted by the release below, this information is subject to re-disclosure and may no longer be protected the Health Insurance Portability and Accountability Act of 1996.

(Please initial the statements to show your authorization)

— **I agree to my picture, video, audio, artwork or likeness of me being taken by Insight.**

— **I agree to the release of my picture/photograph, video, audio, artwork or likeness with my authorization without any identifying information.**

— **I agree to the release of my first name only with a picture or likeness of my picture/ photograph, video, audio, artwork or likeness with my authorization.**

Informed Consent to Video Record Sessions

ABA Insight is committed to providing high quality ABA services to its clients and families. We also support the teaching and training of staff pursuing their certification in Behavior Analysis. Video recording sessions are a critical component of ensuring quality services (i.e., client safety and staff performance and training). Feel free to ask your Program Behavior Analyst any questions about the purpose and use of video recording.

Your signature below indicates that you give ABA Insight permission to video record your child, and that you understand the following:

1. The purpose of recording is for client safety, monitoring staff performance, and training. Therefore, the recordings may be reviewed by the Owner & Executive Director, Clinical Director, Manager of Quality Assurance, Program Behavior Analysts, and Behavior Technicians. Also, if your child receives funding for services through the local Community Mental Health, recordings may be viewed if there is concern of neglect or abuse or for purposes of reviewing any incident reports that were filed.

2. The contents of recordings are confidential, and the information will not be shared outside the context of which the purpose for reviewing the recording.

3. The recordings are stored on a secure DVR located on the premises of ABA Insight offices.

4. The recordings are written- over as the drive becomes full; the oldest recordings being recorded-over first, and so on and so forth.

____

Name of Guardian (Please print)

____ _______________

Signature of Guardian Date

AUTHORIZATION TO RELEASE CLIENT WITH/WITHOUT INFORMATION

I, ______________________________, am the legal parent/guardian of _________________________, my son/daughter; born on: __________________. I can be reached at __________________________. I give the staff of ABA Insight LLC permission to release my child and/or share and/or discuss my child's medical information with the following individual(s) (family and/or friends):

Printed First and Last Name	Relationship	Phone Number	Share my child's information	Release my child to their custody
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No

I understand that I may withdraw this consent at any time (by writing to ABA Insight), but that withdrawing this consent will not affect any information that has already been released.

I understand that I do not have to sign this form, and that should only sign it if I want my child's information shared with someone.

This authorization expires _____________ OR when I cancel/withdraw it in writing. If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.

______________________________________ ________________________

Parent/Guardian Signature Date

_______________________________________ ________________________

Witness Signature (ABA Insight LLC) Date

SAFETY CARE (Registered Trademark of QBS) DISCLAIMER

ABA staff are certified in Safety-Care. Safety-Care is a training program for staff working with individuals who may exhibit dangerous behaviors. The focus is on prevention, safety, humane, supportive, and evidence-based interventions. ABA Staff are trained to prevent many behavioral crises and how to respond if a crises occurs.