New Client Application

Rochester Center for Autism
3640 9th Street NW
Rochester, MN 55901

Dear Parents/Guardians,

Welcome to the Rochester Center for Autism! We are grateful that you are interested in our program and look forward to meeting you and your family. The Rochester Center for Autism opened its doors in Rochester, MN in April of 2004. It is a center-based ABA (Applied Behavior Analysis) program that provides one-on-one therapy for children diagnosed with Autism, as well as other Autism Spectrum Disorders. The Center looks to provide quality, caring service to each child that is enrolled. Each staff member is highly trained and dedicated to meet the needs of the families and children they serve.

The first step in enrolling in our program is completing the necessary paperwork for your child. Please thoroughly fill out each page of the client application packet that is provided below. Once you have completed the forms you may submit it by mail, drop it off or fax it to the Center. In addition to the application packet, attach all medical documentation relating to the autism diagnosis (this must include the 5 AXIS) and a copy of your child's insurance card. I will be in contact with you when I receive the application packet to continue the intake process. If you have any questions along the way, please contact me during our scheduled business hours.

Thanks again for your interest in our program!

Sincerely,
Jaclyn Burton
Intake Coordinator/Lead Therapist
Rochester Center for Autism
(507) 424-3234 fax (507) 424-3235
jaclynburton@rcenterforchildren.com

Client Registration Information

Rochester Center for Autism
3640 9th Street NW
Rochester, MN 55901

Start Date _____ (RCA will fill in)

Today's Date _____

Client:

_____
Last Name First Name Initial

Sex of client: M___ F___ Age: _____ Birthday: _____ Client's Social Security #:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____ Cell #: _____

E-mail Address for Contact Information_____

Preferred Method of Contact (please rank in order)

Home Phone Number ____ Cell Phone Number ____ Work Phone Number ____ Email Address____

Siblings (list names and ages): _____

Parent/Guardian 1 Name: _____

Social Security #: _____

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone #: _____

Parent/Guardian 2 Name: _____

Social Security #: _____

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone #: _____

Medical Background

Does your child have any medical conditions? Yes / No

If yes, please list any special problems such as allergies, existing illness, previous serious illness, injuries during the past 12 months, any medication prescribed for long-term continuous use, and any other information which staff should be aware of.

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Insurance and Payment Information

Name of Primary Insurance _____

Member Number_____ Group Number: _____ Subscriber Name_____

Name of Secondary Insurance _____

Member Number: _____ Group Number: _____ Subscriber Name: _____

Medicare #_____ Medicaid #_____

I prefer:
___ Pay my balance in full at time of service.
___ Pay my balance in full upon receipt of first statement.
___ Make payment arrangements prior to services being rendered.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____hereby authorize_____
(Name of Insured) (Name of Insurance Company)

To pay and hereby assign directly to Rochester Center for Autism all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all changes incurred. I further acknowledge that any insurance benefits, when received by and paid to Rochester Center for Autism will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized signature of Subscriber) (Date)

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Therapy Options

The Rochester Center for Autism offers both in-home and center-based therapy for clients enrolled in our program. Please complete the form below to indicate which therapy you prefer for your child. The information you provide will help us to determine the type of therapy you are seeking for your child. For more specific details regarding either program you may contact the Center or go to our website at www.rcautism.com .

Please circle:

1. What is your 1st preference?
   In-Home Therapy Center-Based Therapy Combination

2. What is your 2nd preference?
   In-Home Therapy Center-Based Therapy Combination NONE

3. Do you want to be notified for the first available program?
   YES (I would take first available) NO (I only want my 1st preference)

Please note that if you circle NO, you will **not be notified when a spot becomes available unless it is your 1st preference.

4. Is there a program you would not prefer or unable to participate in?
   YES NO

   If YES, please explain:

   _____
   _____
   _____
   _____
   _____
   _____

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Strengths

Please list all of your child strengths such as drawing, writing, computer, etc.

Main Concerns

Please list any concerns the child may have at home or in the community. This may include, but not limited to, sensitivity (i.e. oversensitive to noises, oversensitive to certain material or texture of food), behaviors, communication, social skills and play skills. Additionally, provide any special accommodations that would help staffs to better support the child's progress.

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Possible Reinforcers

Please list all or any preferences that your child has shown and put * next to the ones that are highly preferred in each category. Be SPECIFIC as possible!!

FOOD: (snacks, candies, chocolate – please be specific; kind or brand names)

TOYS: (games, stuff animals, etc.)

PHYSICAL CONTACT: (tickles, hugs, kisses, clapping, back rubs, etc.)

ACTIVITIES: (reading books, listen to music, etc.)

OTHERS: (any special preferences not mentioned)

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Service Coordination

Child's Name: _____ Date: _____

Service Coordination:

Minnesota Statutes governing Children's Therapeutic Services and Supports require providers to coordinate services. If your child is receiving any of the following, indicate the number of hours of service per day and the frequency of the service.

Service	Number of Hours	Frequency
Special Education Services		
Child Welfare- Targeted Case Management (CW-TCM)		
Community Alternatives for Disabled Individuals (CADI) Waiver		
Personal Care Assistant (PCA)		
Mental Health- Targeted Case Management (MH-TCM)		
Recreational Therapy		
Psychiatrist		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Collaborative/Wraparound Services		
Other (explain)		

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Release of Consent

Client name: _____

A separate Consent for Exchange of Information form must be completed for each individual or agency you wish for RCA to communicate with.

- I understand that my records are protected by data practice laws and cannot be released without my consent unless otherwise allowed by law.
- I understand that only the information and records indicated below will be released or obtained.
- I understand that this consent does not authorize the recipient of the information or records to re-disclose the information or records to any other person or facility unless authorized by law.
- I understand that the information will only be used for the purposes indicated below.
- I understand that I may withdraw or modify this consent at any time but, that the revocation or modification will not affect any release of information that previously occurred.
- I understand that this consent with expire and no longer be valid **one year** from the date it was signed.
- I understand that the observation and/or assessment can take place in either setting.

I Authorize:

Rochester Center for Autism
3640 9th St NW
Rochester, MN 55901
Name of Staff: _____

To obtain records from or release records to:

Name of Agency: _____
Name of Staff: _____

Type of information released:

___Assessments or evaluations
___Behavior reports
___All
___Educational records
___Medical records
___Other: _____

Information may be shared in person or by mail, I also give permission to share information using the following methods:

___Phone
___Fax
___All
___Email
___Other: _____

_____ _____
Parent or Guardian or Authorized Representatives Signature Date

Federal Law: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law prohibits disclosing this material. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

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Rochester Center for Autism Consent Form

I, _____, as parent/legal guardian of _____, give permission for my child/ward, (hereinafter "Participant") to participate in the Rochester Center for Autism Early Childhood Program. I have received an enrollment application package and have read, understood and completed all the necessary forms required prior to enrollment. I agree with the current personal development goals established for Participant, and I am aware that I will be required to attend periodic meetings for review and revision of Participant's individual program. I also understand that I may withdraw Participant at any time. I understand that the Rochester Center for Autism reserves the right to terminate the enrollment of Participant for failure to adhere to program standards.

I have given all emergency contact information to the Rochester Center for Autism.

I also give permission for the Rochester Center for Autism to use any necessary information and data collected on Participant to be reviewed and used in presentations at any professional meetings and conferences. I understand that Participant's name and identity will be kept confidential and will not be disclosed without prior written notification. I also understand that this will serve to further the advances in the field of autism.

I hereby agree to hold harmless and release from any and all liability, the Rochester Center for Autism, its directors, officers, employees, agents, affiliates, sponsors, and promoters, as well as, their respective directors, officers, employees, and agents (hereinafter collectively known as "the Rochester Center for Autism and its Sponsors"), for any injury or illness to the Participant, arising out of or in connection with his/her participation in the Rochester Center for Autism program. Also, to the fullest extent allowed by law, I hereby waive and discharge my and the Participant's rights, including those of our heirs and assigns, to any and all claims of damages for injury or illness to the Participant, against the Rochester Center for Autism program. I agree that health insurance coverage for the Participant is my sole responsibility.

Parent/Guardian comments:

_____
_____
_____
_____

Parent/Guardian Name (please print): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Client Notification of Privacy Rights
Health Insurance Portability and Accountability Act (HIPAA)

Recent federal law, the Health Insurance Portability and Accountability Act (HIPAA), has created new client protections surrounding the use of protected health information. Commonly referred to as the " medical records privacy law," HIPAA provides client protections related to electronic transmission of data, the keeping and use of client records, and the storage and access to health care records. HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Client Notification of Privacy Rights is designed to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can do to protect the privacy of your mental health records.

HIPAA requires that we secure your signature indicating you have received or been offered the Client Notification of Privacy Rights document.

I have accepted a copy of the Client Notification of Privacy Rights document. _____

I have been offered a copy of the document and do not wish to have a copy at this time. _____

I understand I have the right to review the document before signing this acknowledgement form.

_____ _____
Client's Name (print) Client or Legal Guardian Signature

_____ _____
Client Date of Birth Date Signed

Please sign and return this page to the office. You may retain the notification document for you records.

HIPAA Privacy Rights Notification 06-

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Mayo Clinic Psychology Department

Throughout the year, the Rochester Center for Autism has the opportunity for residents from the Mayo Clinic Psychology Department to observe therapy as part of their 2-year fellowship. This will give them a first-hand look of ABA therapy and clients diagnosed with Autism Spectrum Disorder. The residents will shadow various clients throughout their fellowship at RCA. Throughout their observations the residents seek background information regarding a particular client which may include: age, diagnosis, time spent in therapy, medical history, etc. Mayo Clinic employees are bound by the Health Insurance Portability and Accountability Act (HIPAA), and cannot share any information obtained from staff at the Center to anyone outside of the facility. It is the right of the parent/guardian to deny anyone from observing their child, including Mayo Clinic employees. A consent form will be given to the family upon enrolling in our program for observation purposes.

_____I give permission for a resident from the Mayo Clinic Department of Psychology to observe my child. I understand that if the resident has suggestions and/or questions regarding my child's programming that my child's supervisor will inform me as soon as possible.

_____I give permission for a resident from the Mayo Clinic Department of Psychology to read my child's file.

_____I DO NOT give permission for any resident from the Mayo Clinic Department of Psychology to observe my child or read my child's file.

_____ _____
Client's Name (print) Client or Legal Guardian Signature

_____ _____
Client Date of Birth Date Signed

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Today's Date:_____

FACE Sheet

Please complete the form below by providing as much information as possible regarding your child. This information will be given to medical personnel in case of an emergency.

Name	
Birth Date	
Parent/Guardian	
Home Address	
Home Phone Number	
Cell Phone Number	
Work Phone Number	
Primary Insurance	Name:
	Member Number:
	Group Number:
Secondary Insurance	Name:
	Member Number:
	Group Number:
Hospital/Clinic Preference	
Primary Doctor	
Allergies	
Other Information	
Rochester Center for Autism	3640 9th Street NW (507)424-3234

Parent/Guardian Name (please print): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Additional Information

Thank you for completing the client registration packet. In addition to submitting the application packet, please include the following items when applying for enrollment:

- Copy of your child's insurance card(s)
- Medical documentation pertaining to the diagnosis of autism
- Reports from other service providers (if applicable)
    - Speech therapy, school services, occupational therapy, etc.

Please contact the center if you have any questions when completing the application packet, or regarding the intake process.

Thanks again,

Jaclyn Burton
Intake Coordinator/Lead Therapist
Rochester Center for Autism
(507) 424-3234 fax (507) 424-3235
jaclynburton@rcenterforchildren.com

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Parent Support Group

The Rochester Center for Autism offers a support group for parents, guardians and others who work closely with children diagnosed with Autism.

- We welcome parents diagnosed with Autism of any age. The Autism support group looks to offer guidance, counsel, aid, comfort, understanding and bonding to all those who raise or work with children on the spectrum.
- Additionally, staff and volunteers trained by the Center provide childcare to help ensure all family members can attend. There is a small fee for utilizing the childcare services during these support groups.
- The group gathers once a month at the Rochester Center for Autism and is led by Jaclyn Gunderson, Clinical Trainee, MHPr, Kelli Branstad, Clinical Trainee, MHPr, employees from the Center.
- Groups are sometimes focused on particular topics of interest (ex. how to deal with behaviors in the home) and other sessions provide an open discussion forum.

The Parent Support Groups typically run the last Wednesday of each month from 6:30-8:00. Most months during the school year a family meal is also served prior to the group to make our support groups more accessible for families. If you would like more information about the parent support group you may call the Center or contact Kelli Branstad at kellibranstad@rcenterforchildren.com

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Sibling Support Group

Rochester Center for Autism welcomes siblings of children with Autism Spectrum Disorders to join us for a monthly Sibling Support Group! At our sibling group, brothers and sisters will meet other siblings of children who have Autism Spectrum Disorders. They will get a unique opportunity to talk with other kids who understand what it's like to have a sib with special needs. Most importantly, they will also have a good time!

- The group is for brothers and sisters (including step-siblings) of children who have Autism Spectrum Disorders ages 4 and up. Those who attend the group are not required to be legal siblings. Families do not need to be clients of RCA to register.
- The cost is $10 for the first child and $5 for each additional child. This fee applies for both the Sibling Group as well as the childcare group.
- There will often be an optional family meal from 6-6:30, and is made available free of cost through generous funding from the RT Autism Awareness Foundation.
- The Sibling Support Group typically runs the last Wednesday of each month during the school year from 6:30-8:00, the same time as the Parent Group. A parent does not need to be in attendance at the Parent Group for the Sib to participate in the Sibling Group.

All Sibling Group participants must RSVP by the deadline to reserve their spot. To be added to the email list to receive notifications on the Sibling or Parent Support groups, please contact Kelli Branstad at 507-424-3234 or by email at kellibranstad@rcenterforchildren.com