

**For Office Use Only**

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**REGISTRATION PACKET  
2019-2020**



Name of Child: \_\_\_\_\_  
(First) (Middle) (Last)

Child's Date of Birth: \_\_\_\_\_ Child's Age: \_\_\_\_\_ Child's Sex: M F

Child's Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Parent's Cell (main) Phone: \_\_\_\_\_

Child's Social Security #: \_\_\_\_\_

*Bluegrass Center for Autism admits children of any race, color, national and ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to children at the center. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its policies, admissions policies and other center-administered programs.*

## Parent/Guardian Information

*(adult(s) with whom the child lives)*

Parent/Guardian Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer of Parent/Guardian: \_\_\_\_\_

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Additional Parent/Guardian Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer of Parent/Guardian: \_\_\_\_\_

*PLEASE NOTE: In order for your child's experience at Bluegrass Center for Autism to be successful, we require each adult family member to attend team conferences, and parent workshops to ensure effective reinforcement may occur at home.*



# Medical Information

*Please complete medical information for all that apply*

## Child's Primary Care Physician

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

(Street) (City) (State) (Zip Code)

## Child's Specialty Care Physician

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

(Street) (City) (State) (Zip Code)

## Child's Psychologist/Psychiatrist

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

(Street) (City) (State) (Zip Code)

## Child's Dentist

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

(Street) (City) (State) (Zip Code)

## Child's Ophthalmologist

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

(Street) (City) (State) (Zip Code)

## Medical Information (continued)

*Please check all that apply for your child enrolling in BCA*

<input type="checkbox"/> Allergies: <input type="checkbox"/> Food: _____ <input type="checkbox"/> Insects: _____ <input type="checkbox"/> Drugs: _____ <input type="checkbox"/> Latex <input type="checkbox"/> Seasonal: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Asthma or Breathing Conditions <input type="checkbox"/> Asperger's Syndrome <input type="checkbox"/> Attention Deficit Disorder (ADD) <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) <input type="checkbox"/> Autism Spectrum Disorder (ASD) <input type="checkbox"/> Bladder Conditions <input type="checkbox"/> Bowel Conditions	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Dental Conditions <input type="checkbox"/> Diabetes <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Head/Spinal Injuries <input type="checkbox"/> Deaf or Hearing Impaired <input type="checkbox"/> Heart Conditions <input type="checkbox"/> Muscle Conditions <input type="checkbox"/> Seizures <input type="checkbox"/> Speech Delays/Conditions <input type="checkbox"/> Visually Impaired/Blindness <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
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Date of last eye exam: \_\_\_\_\_ Date of last hearing test: \_\_\_\_\_

Please describe any other important medical/health related information about your child:

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Please list all your child's medications, prescriptions, supplements (including over-the-counter medication) below. Use extra page for additional medications, prescriptions and supplements.

<u>Medication</u>	<u>Dosage</u>	<u>Times per day</u>	<u>Condition</u>	<u>Physician</u>

*Please Note: Please make BCA staff aware of any adjustments/changes that are made to your child's medications.*

## Medical Information (continued)

In an emergency, do you give Bluegrass Center for Autism's staff permission to send your child (properly supervised) to an alternative hospital or physician, if you and/or your physician(s) cannot be reached? (circle one)                      Yes                      No

*As a parent/guardian, I authorize treatment of \_\_\_\_\_ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Documentation of your child's previous evaluations are needed. Specifically, but not limited to:

- Educational Evaluations/Plans
- Psychological Evaluations
- Speech and Language Evaluations/Plans
- Occupational Therapy Evaluations/Plans

## Medical Information (continued)

Does your child have an Autism Spectrum Disorder (ASD) diagnosis? (circle one)    Yes                    No

Who gave your child his/her ASD diagnosis?

Physician's Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Date of ASD Diagnosis: \_\_\_\_\_                    Child's Age when diagnosed with ASD: \_\_\_\_\_

What prompted you to seek an evaluation for your ASD diagnosis? \_\_\_\_\_

Please attach a copy of the original diagnostic evaluation and any additional diagnostic evaluation/treatment summary since that date.

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*Please complete only if your child has received services in any of the following areas:*

### Speech and Language

Therapist's Name: \_\_\_\_\_

Agency: \_\_\_\_\_                    When was your child last assessed? \_\_\_\_\_

What are the goals for this intervention? \_\_\_\_\_

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### Occupational Therapy

Therapist's Name: \_\_\_\_\_

Agency: \_\_\_\_\_                    When was your child last assessed? \_\_\_\_\_

What are the goals for this intervention? \_\_\_\_\_

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### Physical Therapy

Therapist's Name: \_\_\_\_\_

Agency: \_\_\_\_\_                    When was your child last assessed? \_\_\_\_\_

What are the goals for this intervention? \_\_\_\_\_

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**Applied Behavior Analysis (ABA) Therapy**

Therapist's Name: \_\_\_\_\_

Agency: \_\_\_\_\_ When was your child last assessed? \_\_\_\_\_

What are the goals for this intervention? \_\_\_\_\_

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**Medical Information (continued)**

**Psychology or Psychiatric Services/Therapy**

Therapist's Name: \_\_\_\_\_

Agency: \_\_\_\_\_ When was your child last assessed? \_\_\_\_\_

What are the goals for this intervention? \_\_\_\_\_

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Does your child have a diagnosis of Epilepsy, or Seizure Disorder? (circle one)      Yes      No

If yes, please explain the frequency of seizures: \_\_\_\_\_

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## Emergency Information

Child's Name: \_\_\_\_\_

Parent/Guardian names: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Additional Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Email address: \_\_\_\_\_

In the event of an emergency, and the parents/guardians listed above cannot be reached, list the name, phone number and email address of individuals Bluegrass Center should contact (*list should be adults over the age of 18*):

1. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

4. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

*As a parent/guardian, I authorize treatment of \_\_\_\_\_ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only of reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Bluegrass Center for Autism Medical Information Release Form

I, (please print) \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_, a child attending Bluegrass Center for Autism, authorize the transmission of information regarding my child between Bluegrass Center for Autism representatives and my child’s physician(s). I understand that all information regarding my child’s physical, developmental, and emotional health will be kept confidential.

The following is a list of physicians who may be contacted by Bluegrass Center for Autism representatives on behalf of my child:

- Primary Care Physician (Pediatrician): \_\_\_\_\_ Phone: \_\_\_\_\_
- Neurologist (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_
- Psychiatrist (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_
- Behavior Analyst (Home): \_\_\_\_\_ Phone: \_\_\_\_\_
- Outside Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_
- Other: \_\_\_\_\_ Phone: \_\_\_\_\_
- Other: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*PLEASE COMPLETE THE HIPAA PRIVACY AUTHORIZATION FORM (next page) FOR EACH PROVIDER LISTED ABOVE\*

# HIPAA Privacy Authorization Form

\*\*Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)\*\*

1) **Authorization**

I authorize \_\_\_\_\_ (healthcare provider) to use and disclose the protected health information described below to Bluegrass Center for Autism.

2) **Effective Period**

This authorization for release of information covers the period of healthcare from:

a)  \_\_\_\_\_ to \_\_\_\_\_

-- OR --

b)  all past, present, and future periods.

3) **Extent of Authorization**

a)  I authorize the release of the complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) for \_\_\_\_\_

-- OR -- (client name and date of birth)

b)  I authorize the release of the complete health record for \_\_\_\_\_ (client name and date of birth) with the exception of the following information:

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse and treatment

Other (please specify): \_\_\_\_\_

4) This health information may be used by the entity I authorize to receive this information for medical/mental health treatment or consultation, billing or claims payment, or other purposes as I may direct.

5) This authorization shall be in force and effect until \_\_\_\_\_ (date or event), at which time this authorization expires.

6) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7) I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8) I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of parent or guardian

\_\_\_\_\_  
Relationship to client

**Bluegrass Center for Autism**  
**Medication Distribution Release Form**  
(Prescriptions Only)

I, (please print) \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_, a child attending Bluegrass Center for Autism, authorize Bluegrass Center for Autism employees to administer the following medication(s) in the following dosage to my child. I release Bluegrass Center for Autism from all liability for administering the stated medication in the stated dosage.

- *All medication must be brought to Bluegrass Center for Autism in it's original container, with prescription label on the original container.*
- *This Release does NOT need to be completed for "over-the-counter" medicine and/or supplements, however Bluegrass Center for Autism must be aware of any "over-the-counter" medicine and/or supplements that are given to your child at home.*

Medication (please write the entire name): \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency (how many times per day): \_\_\_\_\_

Instruction for administering (include time of day, special instructions, etc.): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_ Physician's Agency/Group: \_\_\_\_\_

*Please note: Please print this page off for each prescription medication your child is currently taking.*

## Allergy Emergency Plan

*(only complete if applicable)*

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

*As a parent/guardian, I authorize treatment of \_\_\_\_\_ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Type of Allergy: \_\_\_\_\_

Identify the triggers which begin allergic reaction: \_\_\_\_\_

\_\_\_\_\_

Symptoms of allergic reaction: \_\_\_\_\_

\_\_\_\_\_

Instructions if allergic reaction occurs: \_\_\_\_\_

\_\_\_\_\_

Type of Allergy: \_\_\_\_\_

Identify the triggers which begin allergic reaction: \_\_\_\_\_

\_\_\_\_\_

Symptoms of allergic reaction: \_\_\_\_\_

\_\_\_\_\_

Instructions if allergic reaction occurs: \_\_\_\_\_

\_\_\_\_\_

## Seizure Emergency Plan

*(only complete if applicable)*

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

*As a parent/guardian, I authorize treatment of \_\_\_\_\_ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Type of seizure: _____
Identify the triggers which begin seizures: _____
_____
Symptoms of seizures: _____
_____
Instructions if seizure occurs: _____
_____

Type of seizure: _____
Identify the triggers which begin seizures: _____
_____
Symptoms of seizures: _____
_____
Instructions if seizure occurs: _____
_____

## Asthma Emergency Plan

*(only complete if applicable)*

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

*As a parent/guardian, I authorize treatment of \_\_\_\_\_ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Identify the triggers for an asthma attack: _____ _____
Symptoms of an asthma attack: _____ _____
Instructions if an asthma attack occurs: _____ _____

Identify the triggers for an asthma attack: _____ _____
Symptoms of an asthma attack: _____ _____
Instructions if an asthma attack occurs: _____ _____

## Diabetic Emergency Plan

*(only complete if applicable)*

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

*As a parent/guardian, I authorize treatment of \_\_\_\_\_ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Identify the triggers for a diabetic emergency: _____ _____
Symptoms of a diabetic emergency: _____ _____
Instructions if a diabetic emergency attack occurs: _____ _____

Identify the triggers for a diabetic emergency: _____ _____
Symptoms of a diabetic emergency: _____ _____
Instructions if a diabetic emergency attack occurs: _____ _____



# Bluegrass Center for Autism

## Payment Policy

Financial obligations are crucial to the successful operation of Bluegrass Center for Autism. Bluegrass Center for Autism's administration and Board of Directors set and approve our Payment Policy and fees annually. All parents/guardians must sign this agreement in order for their child to attend Bluegrass Center for Autism and agree to make payments as selected below.

**Deposit:** An initial \$500.00 *non-refundable* deposit must be made during the registration process. Deposits will be applied towards the child's annual fees.

### **Payment Option:**

1. \_\_\_ Automatic ACH withdrawal from your checking/savings account. (suggested method)  
If you select this option, please complete the provided ACH form.
2. \_\_\_ Personal Check/Money Order. (Cash is not accepted)

### **Payment Frequency:** Please select payment frequency option: *Uninsured Clients ONLY*

1. \_\_\_ Full payment due prior to the beginning of Regular Session.
2. \_\_\_ Quarterly payments due in August, November, February and May.
3. \_\_\_ Bi-Annual payments due in August and January of Regular Session.
4. \_\_\_ Monthly payments due on the 20<sup>th</sup> of each month.
5. \_\_\_ Bi-Monthly payments due on the 5<sup>th</sup> and 20<sup>th</sup> of each month.

# Bluegrass Center for Autism

## Payment Policy (continued)

### Payment Policies:

1. Failure to submit payments as agreed above will result in your child's dismissal from Bluegrass Center for Autism, and all collection options will be sought if necessary. For default payments please see the additional policy below.
2. A \$50.00 charge will be applied to any account whose ACH payment and/or check does not clear or is declined.
3. Bluegrass Center for Autism does NOT accept cash as a form of payment.
4. Bluegrass Center for Autism payments for services are non-refundable.
5. Families who utilize "Insurance Billing" are responsible for all costs not covered and/or paid by their insurance company, including copays and coinsurance.

I have read, understand and agree to the conditions outlined above. I understand and acknowledge that by signing below, I agree to submit payments as outlined above for all payments due to Bluegrass Center for Autism.

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Name of Child

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Parent Signature Date

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Parent Signature (if applicable) Date

**Bluegrass Center for Autism  
Proposed Aging/Collection Policy**

After 60 days of sending an invoice to a Bluegrass Center for Autism client's family, our Systems and Billing Director will contact any family who has not made full payment of the invoice, or a payment plan is not created and/or followed. The Systems and Billing Director will request full payment of the invoice or a payment plan initiated and implemented.

Within 30 additional days (90 total days from initial invoice sent), if full payment is not made, or a payment plan is not created and/or followed, the Executive Director will contact the family to request full payment of the invoice or a payment plan initiated and implemented.

Within 15 additional days (105 total days from initial invoice sent), if full payment is not made, or a payment plan is not created and/or followed, a letter from the Board of Directors and the Executive Director will be sent to the family requesting that full payment of the invoice is made, or a payment plan is created and followed. The letter will state that failure to make the payment in full, or a payment plan is not created and followed within 15 additional days (120 days total from the initial invoice sent) may result in termination of Bluegrass Center for Autism's services as well as turning the amount owed to a collection agency.

**1/1 Billing due 3/1**

**60-day payment terms**

Within 10 days past due date	Courtesy Call to arrange payment or a payment plan-Billing Director. 10 days late
Once 30 days past due date	Executive Director calls to arrange collection/payment plan. 30 days late.
15 days after ED Call	Letter from ED and Board of Directors that payment must be made within 15 days. 45 days late.
15 days after Board Letter	Board determines status of enrollment in BCA 60 days late. 120 days from invoice date.
After 120 days	BCA will charge the credit on file, if there has been no communication from the parent/guardian.

*\*Approved by BCA Board of Directors on 4/25/2019\**

## AUTHORIZATION SIGNATURE & FINANCIAL INFORMATION

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Parent/Guardian signature line

Date

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Email for financial communication

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Parent/Guardian printed name

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Additional email for financial communication

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Mailing Address for financial communication

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Phone number for financial communication

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Address Line 2

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Name on Credit Card

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Credit Card Number

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Expiration Date

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Security Code (3-digit code)  
(AMEX 4-digit code)

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Billing Zip Code

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Credit Card Type (all major credit card accepted, i.e. Visa, Mastercard, Discover, American Express)

## AUTHORIZATION AND RELEASE

As a courtesy, Bluegrass Center for Autism (“BCA”) will file insurance claims on behalf of qualified participants in our program. However, the client’s Parent or legal Guardian is ultimately responsible for all charges. By completing this Authorization and Release, you acknowledge your consent to provide services and your financial responsibility for those services. Please refer to the Bluegrass Center for Autism – Health Insurance Coverage and Payment Policy for more details regarding payment policies.

### CONSENT FOR SERVICE PROVISION TO A MINOR CHILD or INDIVIDUAL IN LEGAL GUARDIANSHIP

Your signature indicates that you are granting permission for your minor child or individual in your legal guardianship \_\_\_\_\_, Date of Birth \_\_\_\_\_, to receive services at Bluegrass Center for Autism as they deem advisable from this date. Your signature indicates that you are the legal parent or guardian of this minor child/individual and are legally able to authorize treatment for this child/individual. You may be asked to present proof of guardianship by the staff of the Bluegrass Center for Autism in order to proceed with services. This consent will be valid for one (1) year from this date or until consent is revoked in writing. Your signature certifies that you have been made aware of the role and services offered by Bluegrass Center for Autism and consent to care by such providers. Your signature indicates that you understand these services are voluntary and that you have the right to refuse these services.

Name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship to Minor Child/Individual in Legal Guardianship: \_\_\_\_\_

### AUTHORIZATION TO FILE CLAIMS

Please choose Option A or Option B by placing an X and then signing below:

\_\_\_\_\_ Option A: I do not have commercial insurance coverage for services provided by Bluegrass Center for Autism and will be paying for all services out-of-pocket at the current prompt pay adjusted rate. I do not authorize Bluegrass Center for Autism to file claims for services to my insurance plan.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Option B: I hereby authorize Bluegrass Center for Autism to file claims for services to my insurance plan, Medicaid, Medicare, and/or any other government agency for reimbursement. I request that Bluegrass Center for Autism furnish any and all information they may require from my record in order to process such a claim.

Signature of Policyholder: \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name of Policyholder: \_\_\_\_\_  
SSN of Policyholder: \_\_\_\_\_ Policyholder Date of Birth: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_  
Plan Start Date: \_\_\_\_\_ Plan End Date: \_\_\_\_\_ E-mail: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS (if choosing Option B):**

I hereby authorize payment of benefits from my insurance plan, Medicaid, Medicare, and/or any other government or private plan to be paid directly to Bluegrass Center for Autism, which will be credited to my account. I also understand that I am financially responsible for any amounts not covered by my insurance company including copayments, coinsurance amounts, deductibles and any amount over the usual reasonable and customary guidelines.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian

**NOTICE OF PRIVACY PRACTICE RECEIPT**

I have received a copy of and/or had the opportunity to request a copy of Bluegrass Center for Autism "Notice of Privacy Practice".

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian

## Bluegrass Center for Autism – Health Insurance Coverage and Payment Policy

Bluegrass Center for Autism provides Applied Behavior Analysis (ABA) services. Thus, many health insurance plans will help you pay for the services we provide. However, health insurance does not allow Bluegrass Center for Autism or its employees to “signoff” on the work performed by others. Doing so is considered “fraud.” Only the services provided by Bluegrass Center for Autism will be billed under our name.

Health insurance is written by many different companies, and many of those companies write individually tailored plans for specific employers. Thus, BCA cannot tell you what your plan covers. Please read your plan’s coverage booklet, call your Human Resources department, or your insurer’s office to find out what you need to know. If your health insurance will pay a portion of our fees for services, BCA will provide reasonable assistance with your insurance claims. However, please keep these things in mind:

- 1) Bluegrass Center for Autism had no role in deciding what your insurance covers. Your employer decided which, if any, of our services will be covered and how much you (and we) will be paid. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, coinsurance, out-of-pocket maximums, and so forth. Your insurance contract is between you and your company; it is not between BCA and the insurance company.
- 2) You, not your insurance company or any other person or company, are responsible for paying the fees we agree upon. In addition, you are responsible for any copayments, coinsurance, deductibles, and any claims declined by the insurance carrier. In the event that your insurance carrier has not remitted payment to us within 45 days of the date of claim receipt, you acknowledge that the entire account balance becomes your responsibility.
- 3) As a contracted provider (in-network) with Anthem KY, Humana and CareSource Marketplace, Bluegrass Center for Autism will file insurance claims for our services with those entities **after** authorization for treatment is obtained.
- 4) BCA can only bill for services that are authorized by insurance. You are responsible for paying prompt pay adjusted fees until an authorization for services is obtained from your insurance company. If an authorization for services is received for dates that you have previously paid prompt pay adjusted fees, BCA will file insurance claims for those dates as long as they are within a reasonable timeframe and credit your account with any payments you have made above the amount of your “patient responsibility” according to the Electronic Remittance Advice (ERA) from your insurance provider.
- 5) Any required Pre-Authorization or Pre-Certification for insurance is your responsibility. BCA will assist you with the process, but it is your responsibility to obtain necessary authorizations or referrals required by your insurance carrier prior to the commencement of services.

- 6) Insurance companies do not always authorize the number of visits, hours, or days of service provided by BCA. In those instances, you will be responsible for the prompt pay adjusted fees for any additional services not authorized by insurance.
- 7) Insurance companies do not pay for missed appointments or days; these fees remain your responsibility. Anytime BCA is in operation and your insurance cannot be billed for services by BCA, you are ultimately responsible for paying the prompt pay adjusted fees. BCA allows 30.5 hours (one week) of missed time each calendar year (prorated based on start date) before you will be charged No Show Fees.
- 8) BCA will attempt to file claims for **out-of-network insurance claims** at your timely request and our discretion. However, if we are unable to file claims electronically or have rejections of these claims, you will be responsible for prompt-pay adjusted fees for BCA services.
- 9) Failure to make prompt payment for services rendered by BCA can result in placement of your account with a collection agency and the suspension of services. All expenses incurred through these collection efforts will be billed to the parent/guardian.

I/We have read and understand the **Bluegrass Center for Autism – Health Insurance Coverage and Payment Policy**. I/We understand that claims for insurance will not be filed by Bluegrass Center for Autism until acknowledgement of this policy is signed and returned to BCA along with the completed **Authorization and Release** form. This policy will be reviewed at least annually and updated as needed.

Signature of parent(s) or guardian(s)	Date
Printed name of parent(s) or guardian(s)	Printed name of client

Form ACH



# Bluegrass Center for Autism

## ACH Form

*(only complete if applicable)*

### Payer's Contact Information

Child's Name: \_\_\_\_\_

Payer's Name: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_

Payer's Address: \_\_\_\_\_  
*Street City State Zip*

Payer's Phone: \_\_\_\_\_

Payer's Email Address: \_\_\_\_\_

### ACH Banking Information

Select one: \_\_\_\_: Checking Account \_\_\_\_: Savings Account

Please attach a "VOIDED" check to this form –or– complete the information below:

Bank Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

*I hereby authorize Bluegrass Center for Autism to initiate debit entries to my account indicated above (or attached) and my bank, to debit the same such amount. This authority is to remain in full force and effect until Bluegrass Center for Autism and my bank have received written notification from me of its termination. I hereby agree to any and all information and agreements noted above.*

Payer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Bluegrass Center for Autism

## Media Release Form

Child's Name: \_\_\_\_\_

I, the parent/legal guardian grant my permission for Bluegrass Center for Autism to exhibit photographs, audio, video and/or likeness of the above-named child in print and/or electronically for Bluegrass Center for Autism purposes only.

I agree that Bluegrass Center for Autism may use such photographs, audio, or video of my child for any lawful purpose, including BCA sanctioned purposes such as publications, newspaper articles, professional development, marketing materials, BCA website, BCA social media, hallway bulletin boards, classroom decorations or other such material.

I have read and understand the above, and give my consent as marked below:

\_\_\_ I/We hereby give permission to Bluegrass Center for Autism to use my child's image for the purposes stated above.

\_\_\_ I/We hereby give permission to Bluegrass Center for Autism to use my child's image only within the confines of Bluegrass Center for Autism (hallways, classrooms, etc.).

\_\_\_ I/We hereby do NOT give permission to Bluegrass Center for Autism to use my child's image in any form or capacity.

Printed name of parent/guardian: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# Bluegrass Center for Autism

## Functional Behavior Assessment Consent Form

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, give my informed consent to the Bluegrass Center for Autism to conduct a Functional Behavior Assessment (FBA) for my child. The purpose of this assessment is to identify a hypothesized function or functions for behavior(s) that may be targeted for reduction. Knowledge of the function(s) of behavior is essential for successful reduction of the behavior and must be known prior to developing a Behavior Plan. This assessment may include the following:

- Indirect assessment
  - Informal and/or structured interviews of parents and/or staff
  - Informal and/or structured interviews of other therapists
- Direct observation
  - Collection of data on the antecedents and consequences to behaviors

As a parent/guardian, you may request the results of this assessment at any point. In addition, results will be discussed with you when your assigned Behavior Analyst reviews your child's Behavior Plan with you.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

# Bluegrass Center for Autism

## Safe Crisis Management Release

I \_\_\_\_\_ parent/guardian to \_\_\_\_\_, a learner and or prospective learner at Bluegrass Center for Autism, give permission for the trained staff at Bluegrass Center for Autism to implement Safe Crisis Management (SCM) procedures with my child, only if necessary. I understand that these procedures will only be used as a last resort and after all other procedures have been implemented but deemed unsuccessful by our Program Director or Program Coordinator. I understand that there is a risk for possible injury to my child but that all precautions will be taken to prevent injury. I realize that these procedures are utilized to keep my child, other children and the staff at Bluegrass Center for Autism safe at all times. A Program Director will notify me that day and provide me with written documents detailing the event, if any SCM restraints are used.

I am aware that staff at Bluegrass Center for Autism have been trained and certified by a certified SCM trainer through JKM Training, Inc.

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Parent Signature

Date

## Before and Aftercare Program Form

Name of Child: \_\_\_\_\_

Bluegrass Center for Autism offers a Before Program daily from 7:30am – 8:45am at each campus. Bluegrass Center for Autism offers an After Care Program on *MOST* Friday's from 1:30pm – 3:30pm. **\*PLEASE SEE THE BCA CALENDAR FOR DATES AFTER CARE IS NOT OFFERED\***

Rates for Bluegrass Center of Autism Before and After Care Program:

**Before Care:**

- 7:30am -7:59am: **\$20.00**
- 8:00am – 8:44am: **\$15.00**

**After Care:**

- 1:30pm – 3:30pm: **\$30.00**

Please select options below. You may adjust this throughout the year as needed, provided you speak with your Program Director first.

1. \_\_\_ Yes, I plan on my child attending the **Before Care Program** at Bluegrass Center for Autism on the days circled here:

**Mondays**                      **Tuesdays**                      **Wednesdays**                      **Thursdays**                      **Fridays**

2. \_\_\_ Yes, I plan on my child attending the **After Care Program** at Bluegrass Center for Autism on the Friday's it is offered.

3. \_\_\_ No, I do **NOT** plan on my child attending the Before and After Care Program at Bluegrass Center for Autism.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Lunch, Snacks and Food Form

*(EAST CAMPUS PARENTS/GUARDIANS ONLY)*

Child's Name: \_\_\_\_\_

Due to the dietary needs of each child at Bluegrass Center for Autism, we are requiring all lunches, snacks and food reinforcers to be brought from home.

Bluegrass Center for Autism will be able to store all lunches/food on a daily basis.

*Please Note: If your child has any food allergies, please make note of these allergies on the E-1 (Allergy Emergency) form.*

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Bluegrass Center for Autism

## Media Release Form

Child's Name: \_\_\_\_\_

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I agree that Bluegrass Center for Autism may use such photographs, audio, or video of my child for any lawful purpose, including BCA sanctioned purposes such as publications, newspaper articles, professional development, marketing materials, BCA website, BCA social media, hallway bulletin boards, classroom decorations or other such material.

I have read and understand the above, and give my consent as marked below:

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\_\_\_ I/We hereby do NOT give permission to Bluegrass Center for Autism to use my child's image in any form or capacity.

Printed name of parent/guardian: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# Goals

Please list long term and short term goals you would like your child to achieve while attending Bluegrass Center for Autism:

## Short Term Goals:

1. \_\_\_\_\_  
\_\_\_\_\_. Time Frame: \_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_. Time Frame: \_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_. Time Frame: \_\_\_\_\_

## Long Term Goals:

1. \_\_\_\_\_  
\_\_\_\_\_. Time Frame: \_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_. Time Frame: \_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_. Time Frame: \_\_\_\_\_



# Educational History

Name of current school or placement: \_\_\_\_\_

How long has your child been enrolled in this current school/placement: \_\_\_\_\_

Reason for seeking placement in Bluegrass Center for Autism: \_\_\_\_\_

\_\_\_\_\_

Please list all schools/placements your child has attended:

1. \_\_\_\_\_ Time Frame: \_\_\_\_\_

2. \_\_\_\_\_ Time Frame: \_\_\_\_\_

3. \_\_\_\_\_ Time Frame: \_\_\_\_\_

4. \_\_\_\_\_ Time Frame: \_\_\_\_\_

5. \_\_\_\_\_ Time Frame: \_\_\_\_\_

What are your child's strengths: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In what area's can your child improve: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have a home program? If yes, please describe the type of program, the frequency of sessions, length of sessions and individuals involved in the sessions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# About your Child

What items/activities are most motivating to your child?

Visual Motivators (*i.e. TV, movies, computer games, cell phones, lights, etc.*) \_\_\_\_\_

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Audio Motivators: (*i.e. music, books with sound, whistles, instruments, singing, etc.*) \_\_\_\_\_

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Touch/Tactile Motivators: (*i.e. squishy/stress balls, sand, lotion, etc.*) \_\_\_\_\_

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Kinetic/Movement Motivators: (*i.e. running, trampolines, rocking, jumping, etc.*) \_\_\_\_\_

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Please list any items/activities your child dislikes: (*i.e. loud noises, swinging, certain toys, etc.*) \_\_\_\_\_

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## About your Child (continued)

Please list and describe behaviors your child currently demonstrates that you would like to see continued or increased: \_\_\_\_\_

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Please list and describe behaviors your child currently demonstrates that you would like to see decreased or stopped: \_\_\_\_\_

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How does your child communicate? \_\_\_\_\_

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Does your child accept “no” when s/he cannot have a desired item/activity? If not, please describe your child’s reaction: \_\_\_\_\_

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Are you successfully able to remove reinforcing items/activities at home and/or in public? Please describe: \_\_\_\_\_

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## About your Child (continued)

Does your child have any diet restrictions? \_\_\_ Yes \_\_\_ No

If so, please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child eat a variety of foods: \_\_\_ Yes \_\_\_ No

If "No", what types of food does your child eat? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have difficulty sleeping through the night? \_\_\_ Yes \_\_\_ No

If so, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything else we should know about your child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Parent/Guardian Volunteering

Throughout the year, Bluegrass Center for Autism hosts and participates in multiple fundraisers and community functions to help support our mission. Having parent/guardian volunteers help keep the cost down for Bluegrass Center for Autism to staff these events. Bluegrass Center for Autism requires a parent/guardian or family member (over the age of 18) to volunteer for at least one BCA fundraiser or event each year. Please mark next to the event(s) that you or a family member would be interested in volunteering for on behalf of Bluegrass Center for Autism. You are not guaranteed you will be volunteering for the selection you make below, so please select more than one.

- “Highlands Beer Fest” ValuMarket Fundraiser for BCA (usually held in May)
- “Outrunning Autism” FEAT 5K Run/Walk (usually held in June)
- “Boots, Barrels and Bluegrass” BCA Fundraiser Event (usually held in September)
- Major BCA Fundraiser: “Puzzabilities” (usually held in November)
- “Business Expos” Attend Health Fair/Business Expo to hand out BCA info (dates vary)
- Other smaller fundraisers/events throughout the year (dates vary)