ABA checklist

	TASK	DONE
01	FA11 F Form needs to be completed by pediatrician (printed & signed)	☐
02	Signed Consent forms for Revival Therapy	☐
03	Signed Cancellation Policy	☐
04	Checklist for Diagnosis Completed by therapist OR testing report	☐
05	Availability & Demographics Form	☐
06	Prescription 'script' for ABA services	☐

- **FA 11F FORM:** PLEASE PRINT THIS FORM, GIVE TO YOUR DOCTOR, AND ASK THEM TO FILL IT OUT. THIS FORM MUST BE PRINTED, SIGNED, AND FAXED TO US AT 702-944-5498
- **ABA SCRIPT**: PLEASE ASK YOUR DOCTOR TO FAX A 'SCRIPT' FOR ABA SERVICES TO US AT 702-944-5498
- **CHECKLIST FOR DIAGNOSIS** MUST BE COMPLETED BY CLIENT'S THERAPIST **IF** A TESTING REPORT HAS NOT BEEN COMPLETED FOR DIAGNOSIS. THIS SHOULD BE PRINTED AND PROVIDED TO YOUR DOCTOR AT THE TIME OF REQUEST FOR SCRIPT AND FA11F FORM
- **CONSENT FORMS** MUST BE SIGNED PRIOR TO ASSESSMENT ALLOWING US TO COMPLETE REQUIRED DOCUMENTATION & PROVIDE SERVICES
- **CANCELLATION POLICY** MUST BE SIGNED PRIOR TO ASSESSMENT & START OF SERVICES
- **AVAILABILITY AND DEMOGRAPHICS** FORM MUST BE COMPLETED PRIOR TO SCHEDULING ASSESSMENT

DEMOGRAPHICS & Availability

CLIENT NAME:

ADDRESS:

DATE OF BIRTH:

LIST OF INDIVIDUALS LIVING IN THE HOME:

GENDER:

CAREGIVER PHONE NUMBER:

CAREGIVER EMAIL:

CURRENT DIAGNOSIS:

SERVICES CURRENTLY ENGAGED IN/DISCHARGED FROM:

(PLEASE CIRCLE): IN HOME OR IN CLINIC

AVAILABILITY FOR SERVICES:

LANGUAGES SPOKEN:

Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services

Instructions: Submit this certification with **initial requests** for ABA services along with FA-11E. Do not submit this form with requests for continued service.

Request Date:	
Recipient Name:	Recipient Medicaid ID:

Practitioner Certification Ordering ABA Services: *Practitioner must be a Physician, Physician's Assistant, Advanced Practice Registered Nurse (APRN) or Psychologist acting within their scope of practice.*

A Practitioner acting within their scope of practice as defined by State law certifies the following:

1. This individual is Medicaid Eligible (any age) and has an established diagnosis of ASD or other related condition for which ABA is recognized as medically necessary.
2. ABA services are required to develop, maintain or restore to the maximum extent practical the functions of the individual for whom they are requested.
3. The individual exhibits excesses and/or deficits of behavior that impede access to age appropriate home or community activities.
4. There is a reasonable expectation that the individual will improve or maintain function to the maximum extent practical with ABA services.
5. Please identify the diagnostic tool utilized to establish the ASD diagnosis as well as qualifying score. Please check the appropriate box below and enter the individual's score for the diagnostic tool used:

   ☐ Autism Diagnostic Observation Schedule, 2nd Ed. (ADOS-2) Score:_____

   Subscales Scores:_____

   ☐ Childhood Autism Rating Scale, 2nd Ed. (CARS-2) Score:_____

   Subscales Scores:_____

   ☐ Gilliam Autism Rating Scale, 3rd Ed. (GARS-3) Score:_____

   Please indicate the subscales presenting concern observed on the rating sheets:

   _____

   ☐ Fetal Alcohol Spectrum Disorders (FASD) Diagnostic category:_____

   Please indicate the diagnostic system/criteria and/or assessment methods used to determine this diagnostic category: _____

   ☐ Diagnostic and Statistical Manual or Mental Disorders (DSM-5):

   If this criterion alone is used as the sole basis for diagnosis, the provider must submit documentation of the specific DSM-5 criteria that were met.

   _____

   ☐ Other: _____ Score:_____

   If this criterion alone is used as the sole basis for diagnosis, the provider must submit documentation of the specific criteria that were met.

Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services

Name of Practitioner: _____

Credentials: _____

National Provider Identifier (NPI): _____

Signature:_____

Date of Diagnosis:_____

Revival Therapy

Mental Health and Occupational Therapy

(702) 808-8141/702-401-1345

1. Consent to evaluate and treat: I voluntarily consent that my child, my family, or myself will participate in a mental health and/or occupational therapy evaluation and/or treatment through Revival Therapy (RT). I understand that the evaluation and/or treatment will be provided with complete and accurate information in the following areas including: the benefits of proposed treatment, alternative treatment modes and services, the manner in which treatment will be administered, expected side effects from treatment and/or risks of side effects, probable consequences of not receiving treatment. Treatment will be administered by a Licensed Clinical Social Worker and/or an Occupational Therapist; via supervised MSW/BSW/MFT or student therapist; OR Occupational Therapist Assistant/Occupational Therapy Student, BCBA, BCaBA, or RBT. Students may also be observing sessions in order to obtain professional experience/certification or licensure.
2. By signing this form, I understand and acknowledge that I have no obligation to obtain both behavioral health and occupational therapy and ABA through Revival Therapy. I acknowledge that receiving these services through RT is not a requirement to receive treatment via RT and these services are not contingent upon one another to obtain treatment through RT. Furthermore, I acknowledge that I have the right to choose a provider and can terminate services anytime.
3. Charges: Fees are based on the type of evaluation and services provided. I am responsible for charges at the time of service and responsible for all charges not covered by insurance.
4. Confidentiality, Harm, Inquiry: Information from my evaluation and any treatment is contained in a confidential medical record at RT and I consent to disclosure for use by Revival Therapy staff for the purpose of continuity of care. Per Nevada mental health law, information provided will be kept confidential with the following exceptions. 1. If the identified client is deemed to present a danger to themselves or others. 2. If there are concerns about abuse or neglect. Or 3. If a court order is issued to obtain records.
5. The Right to Withdraw Consent: I have the right to withdraw my consent for the evaluation and/or treatment at any time by providing a written request to Revival Therapy.

Please check the following that apply:

_____Consent to receive text messages and emails

_____Consent to receive therapy services via Telehealth

_____Consent to confidential information to court or attorney

_____Consent to request treatment records from RT

_____Consent to go into the school and release information regarding the client

_____Consent to be transported by Revival Therapy staff

_____ Other_____

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Name of client_____DOB_____

Signature_____Date_____

Revival Therapy

Mental Health and Occupational Therapy

(702) 808-8141/702-401-1345

Consent to Disclose Personal Health Information

Pursuant Health Insurance Portability and Accountability Act (HIPAA)

I,_____, authorize **Revival Therapy** to disclose the personal information of _____ consisting of: _____ to: _____.

I understand the purpose for disclosing this personal health information to the person noted above. I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Client:_____

Client DOB:_____

Name of Caregiver/Guardian:_____

Signature:_____

Date:_____

Revival Therapy

Mental Health and Occupational Therapy

(702) 808-8141/702-401-1345

Treatment Plan Approval

I,(Caregiver/Guardian) _____ participated in the development of this treatment plan for (Client)_____ and understand that the goals within this plan will be addressed as part of treatment. I further understand that treatment is a collaborative process and I am able to assist in the modification of goals if so desired or if deemed necessary. I understand that I have a choice in servicing providers and that these services have been determined to be consistent with the regulatory definitions set forth by my insurance provider, if covered by insurance.

Client Signature (If appropriate): _____ Date:_____

Guardian/Caregiver Signature:_____ Date:_____

Revival Therapy

NPI 1740832617
carlyaldis@revivaltherapyvegas.com
Phone 702-808-8141/Fax 702-944-5498

CANCELLATION AND MISSED APPOINTMENT POLICY

A therapeutic relationship is built on mutual trust and respect. As such, every effort will be made to be on time for your scheduled appointment, and ask that you give the same courtesy of a call or text when you are unable to keep your appointment. Please read, sign, and date the cancellation and missed appointment policy below.

A cancelled appointment hurts three people: you, your therapist, and another client who could have potentially used the time missed. Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is cancelled without adequate notice, we are unable to fill this time slot by offering it to another current client, a client on the wait list, or a client with a clinical emergency. Without a cancellation fee policy in place, your therapist will lose the opportunity to schedule another client if you late cancel or do not show up.

Clients can cancel or reschedule an appointment anytime, if they provide 24 hours' notice. Rescheduled sessions must fit the therapist's schedule first and foremost. 3 non-consecutive rescheduled appointments may also result in discharge or being placed back on the waitlist as clients are provided with scheduling options based upon current openings offered by their assigned therapist (these are usually scheduled the same day/time weekly). If you cancel an appointment with less than 24 hours' notice, or fail to show up, you will be charged the total fee for the appointment (cash pay clients), or you will be reminded of this policy and given notice of a possible discharge from sessions (3 non-consecutive no-shows or late cancellations).

Some practices have a 48-hour policy. Some even have a 72-hour policy. ***Ours is 24 hours, and we are firm at 24 hours. For Saturday or Sunday appointments, 48-hour notice is required.*** *Our cancellation policy in not a penalty or a punishment. Most clients understand this. Very rarely, there will be a client who will feel that they are being punished when they are charged a late cancellation fee. We want to make sure that you don't feel this way, if someday you miss an appointment.*

It is likely that at some point you might forget about an appointment, or something will come up in your schedule that will result in you missing an appointment. Maybe you'll need to work late or maybe you'll get a sudden onset of the flu. Maybe your kids will have doctor's appointments, or your car will break down, or something unavoidable will come up. We are not upset with clients when they miss an appointment. We understand life happens. In return, our clients understand that scheduling an appointment with one of us is like buying a ticket to an

event. If you miss the event, it doesn't matter why you missed it, or even if it was your first time, you can't turn in your tickets for a refund.

You can cancel your appointment by calling, texting, or emailing your therapist. If you are more 15 minutes late to your appointment time, it will be treated as a late cancellation and this policy will apply. ***Being 15 minutes or more late to your appointment WILL result in the session being cancelled (cash pay AND insurance clients), meaning your session will not be held even if you show up 20 minutes into the session.*** *For insurance clients, it is important to note that our therapists have pre-approved billing codes based upon the minutes within a session held. After 15 minutes, they cannot bill the codes within insurance, resulting in the full cancellation of the session as billing cannot be completed.*

Clients who are unsure if they can commit to therapy appointments scheduled for them should discuss possible referral options with the therapist or administrative team, OR ask to be provided with an alternative scheduling option (biweekly or even monthly sessions).

Because your therapist believes that the responsibility for your care is on both the client and the therapist, we agree that if you are double-booked for an appointment or if we miss an appointment without notice you will receive a FREE therapy session.

PLEASE INITIAL THE FOLLOWING

_____ **1. If you are unable to keep a scheduled appointment, please contact your therapist with at least 24 hours in advance** (If your appointment is 1pm on Tuesday, notice should be provided no later than 1pm on Monday). **For Saturday or Sunday appointments, 48-hour notice is required.**

_____ **2. For our cash pay clients: If you fail to notify your therapist with a minimum of 24 hours in advance of the cancellation and you miss your appointment, you will be charged the full fee for the session.**

_____ **3. At the time of cancellation, another appointment will be offered based upon the therapist's scheduling availability.**

_____ **4. Three (3) missed appointments - they need not be consecutive - will result in an administrative discharge from the practice OR placement back on our waitlist. For ABA clients, 10 hours of cancelled or missed appointments during an authorization will result in discharge of services.**

I HAVE READ AND UNDERSTAND THE ABOVE POLICY

_____

Print Name

_____

Signature Date

Revival Therapy

dannyaldis@revivaltherapyvegas.com
Phone 702-808-8141/Fax 702-944-5498

Least Restrictive Environment
Treatment Agreement

Revival Therapy is committed to providing quality and caring treatment services to meet our clients' needs. In order to maintain effective services we offer sessions within the least restrictive environment, which includes in home therapy. In home therapy is also convenient for families since we travel to the client's residence. In order to begin in home services, it is important to create a home environment that optimizes treatment. Therefore, below are requirements to ensure clients receive the best possible outcomes and our therapists work in a safe and conducive environment.

Please initial all below as an agreement to obtain these services:

_____ There must be an adult (18 years or older) within the residence at all times

_____ The treatment area inside the residence will be well lit

_____ Due to possible allergies and the safety of our therapists, animals will be put away or removed from treatment area

_____ Treatment area will be clean and ready for sessions prior to therapist's arrival

_____ Client will be on time for sessions

_____ Television and music will be turned off within treatment area to avoid distraction

_____ Unless otherwise requested by therapist, siblings or peer family members will not be in session area to limit distractions

_____ _____
Print Name of client/caregiver Signature of client/caregiver

_____
Date