AUTISM TREATMENT CENTER, INC.
PATIENT INFORMATION

Patient Name: _____

Insurance #: _____

Patient Name:_____ DOB: _____ Age: _____ Sex: M / F

Parent/Guardian Name: _____ Phone: (_____)_____

Address: _____ City: _____ St: _____ Zip:_____

Social Security Number: _____/_____/_____ Dominant Language: ☐English ☐Spanish ☐_____

Patient/Parent/Guardian Information:

Employer: _____ Phone: (___)_____

Address: _____ City: _____ St: _____ Zip:_____

Emergency Contact:_____ Relationship:_____

Address: _____

City: _____ St: _____ Zip:_____ Phone: (___)_____

Referring Physician: _____ Primary Physician:_____

Referring MD's Phone: (___)_____ Primary MD's Phone: (___)_____

Referring Doctors Office: _____ Primary MD's Office: ___ _____

Primary Insurance:_____ Address:_____

Phone: (___)_____ City: _____ St: _____ Zip:_____

Name of Insured: _____ Relation to Patient: ☐Parent ☐Self ☐Spouse

Policy Number: _____ Group #: _____ ☐ Other: _____

Employer: _____ Ph: _____ City: _____ St: _____ Zip:_____

Patient Release and Insurance Authorization: (***Initials are required for release of Medical Information and Authorization of Payment)***

___ I hereby authorize payment directly to the Center for the benefits due to me in my pending claim and/or Major Medical Benefits otherwise payable to me, but not to exceed the physician's and/or the Institutes regular charges for therapy for this treatment period.

___ I further authorize the release of any medical information required by my insurance carrier(s) and/or treating physicians

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Notice: Misrepresentation and/or falsification of essential information requested in this document may be subject to monetary fines and/or imprisonment, if convicted, under federal law.

My signature Indicates that I have read and understood the packet provided upon my admission to the Center. This packet includes a consent form, insurance and medical release form, and insurance benefits assignment / financial agreement.

_____ _____

Signature of Patient/Parent or Legal Guardian Date

_____ _____

Facility Representative Date

Autism Treatment Center

Changing Lives. Building Futures.

Rehabilitation Agency

10610 Metric Dr. Ste. 101
Dallas, TX 75243
Telephone: (214) 221-4405 Fax: (214) 221-4463

Physician's Order/Referral Form

Name: _____DOB: _____Phone#: _____
Address: _____Medicaid #: _____
Please completed the following (indicate N/A if not applicable)
Primary Diagnosis (ICD-9 code/ICD-10): _____ Second Diagnosis: _____
Other: _____Date of Onset: _____
Date Patient Last Seen Physician: _____
Precaution/ Contraindication: _____
PLEASE CHECK ALL THAT APPLY:

□ **Speech Therapy**	□ **Occupational Therapy**	□ **Physical Therapy**
□ Evaluation and Therapy	□ Evaluation and Training	□ Evaluation and Training
□ Motor Speech Disorders	□ Activities of Daily Living	□ Activities of Daily Living
□ Feeding Difficulties	□ Functional Activities	□ Functional Activities
□ Cognitive Activities	□ Pediatric Assessment and Treatment	□ Pediatric Assessment and Treatment
□ Voice Disorders	□ Sensory Integration	□ Post-Surgical Rehabilitation
□ Articulation	□ Upper Extremity Rehabilitation	□ Upper Extremity Rehabilitation
□ Stuttering	□ Post-Surgical Rehabilitation	□ Lower Extremity Rehabilitation
□ Developmental Anomalies	□ Developmental Anomalies	

Further Instructions and/or precautions:

_____

_____

Physician Information:

Physician Name (printed) _____
UPIN #_____NPI#_____
Address: _____
_____
Phone #:_____Fax#:_____
Physician Signature:_____
Date:_____

Patient Name: _____

Insurance #: _____

Autism Treatment Center, Inc.
Medical Records Release/Request Form

(Check One)

- ☐ **Release –** Releasing information from us to you or your provider
- ☐ **Request –** Requesting information from another provider to us

Date: ___ / ___ / ___

Name: _____ Date of Birth: ___ / ___ / ___
Address: _____
City/State/Zip: _____
Phone: _____ Social Security #: _____ - _____ - _____

I authorize Autism Treatment Center, Inc. to release / request (circle one) **the following information:**

Information Requested / Released (circle one): _____
_____
_____

To/From (circle one): _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

- I understand that this authorization shall be valid through ____ /_____ /_____ (date), but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and copy the information released.
- I understand that if I refuse to consent to disclosure if information, the agency may be unable to serve me and/or be able to provide the most appropriate care for me.
- I understand that the release of information may not be re-released to any other person or organization without my written consent.

Patient or Parent (if minor): _____ Date: ___ / ___ / ___

Witness by: _____ Date: ___ / ___ / ___

Autism Treatment Center, Inc.
MEDICAL HISTORY QUESTIONNAIRE

Patient: _____ DOB: _____ Insurance ID#:_____

Does the patient suffer from allergies? ☐ **No** ☐ **Yes If yes, please explain**_____

Does the patient suffer from diabetes? ☐ **No** ☐ **Yes If yes, please explain**_____

Medications: ☐ **No** ☐ **Yes (See Current Medication List)**

History of seizure disorder: ☐ **No** ☐ **Yes If yes, please explain**_____

Medications: ☐ **No** ☐ **Yes (See Current Medication List)**

History of Gastrointestinal problems : ☐ **No** ☐ **Yes** ☐ **Reflux** ☐ **Colic** ☐ **Digestive Problems** ☐ **Failure to Thrive**

Medications: ☐ **No** ☐ **Yes (See Current Medication List)**

History of heart problems: ☐ **No** ☐ **Yes If yes, please explain**_____

Medications: ☐ **No** ☐ **Yes (See Current Medication List)**

History of respiratory disorders: ☐ **No** ☐ **Yes:** ☐ **RSV** ☐ **Bronchopulmonary Dysphasia** ☐ **Pneumonia** ☐ **Asthma**
☐ **Chronic Respiratory** ☐ **Sinus Infection**

Medications: ☐ **No** ☐ **Yes (See Current Medication List)**

Is the patient currently taking Antibiotics: ☐ **No** ☐ **Yes: (See Current Medication List)** ** ***If yes, fill out Infection Control Form.***

Family history of developmental problems or genetic disorders:
☐ **Yes**: Which:_____ Family Member: _____
☐ **No** (Examples: Learning difficulties, Attention Deficit Disorder, Psychological Problems, Behavior Disorders, Cerebral Palsy)

Previous therapy services in the past?
☐ **Yes**: When:_____ Where:_____
☐ **No**

Birth History: ☐ **Full Term Pregnancy** ☐**Partial Term: _____Weeks Gestation**
☐ **Natural Birth** ☐ **C-Section** ☐**Complications:**_____

Complications following Birth: ☐ **Feeding Difficulties** ☐ **Jaundice** ☐ **Respiratory Difficulties** ☐ **Congenital Defects**

Developmental History: Hospitalizations Since Birth: ☐ **No** ☐ **Yes**: _____ For: _____

At what age did your child do the following? _____Babbled _____Sat up unassisted _____ Crawled _____ Stood _____ Walked _____ Said first words _____Combined words _____Toilet Trained

Vision Problems: ☐ **No** ☐ **Yes If yes, explain:** _____

Glasses: ☐ **No** ☐ **Yes If yes, explain:**_____

Auditory: Localizes to sound: ☐ **No** ☐ **Yes Has hearing been checked**: ☐ **No** ☐ **Yes, When:** _____
Results: _____

History of Ear Infections: ☐ **No** ☐ **Yes How many per year:**_____

History of Hearing Problems: ☐ **No** ☐ **Yes If yes, explain:**_____

Autism Treatment Center, Inc.
MEDICAL HISTORY QUESTIONNAIRE

Patient: _____ DOB: _____ Insurance ID#:_____

Does the child have PE Tubes? ☐ No ☐ Yes If yes, explain: _____

Currently taking Medications: ☐ No ☐ Yes ☐ See Current Medication List

Other Specialists:
☐ Physician ☐ Psychologist ☐ Psychiatrist ☐ Geneticist ☐ Neurologist ☐ Cardiologist
☐ Audiologist ☐ ENT Specialist ☐ Other:_____

Name of Specialist if applicable_____

Occupational Therapy Questions/Information:

At what age (in months) did your child: sit alone _____ crawl on tummy _____creep on hands and knees _____

Pull to stand_____ walk alone_____

Parents Concerns:
Does he /she seem overly sensitive to (check):
Being touched_____
Being hugged _____
Having face washed or hair cut _____
Eating certain foods, flavors or textures_____ (list) _____

Wearing certain clothes_____ (list) _____

Does he/she avoid:
Touching things or getting dirty? _____

Covers ears of hide head around certain noises? _____

Which hand is used more often? _____

Self Help: (Please check any of the following your child CAN do)

_____ suck from a bottle/straw

_____ drink from a cup held for him/her

_____ hold and drink from a cup with sipper top ____ without a top

_____ finger feed

_____ feed self without help

_____ hold a spoon

_____ scoop with a spoon

_____ use a fork

_____ use a knife to spread _____/ to cut

_____ Eats with much spilling _____/ little spilling _____/ no spilling

Autism Treatment Center, Inc.
MEDICAL HISTORY QUESTIONNAIRE

Patient: _____ DOB: _____ Insurance ID#:_____

Are there any eating concerns (picky eater, avoidance of food textures or tastes, drooling, poor control of food in mouth)?

_____

Dressing: (Yes, no, needs help)

Removes: Shoes_____ shirt/jacket _____ pants_____ underpants_____
Puts on: Shoes _____ shirt/jacket _____pants _____underpants _____

Describe any help needed: _____

Is your child toilet trained? _____

Psychological and Play:
Does your child have difficulty?
Paying attention? _____
Sticking to one activity for 2-3 minutes? _____ for 15-20 minutes? _____

Does your child:
Have difficulty switching activities? _____

Have rituals or need to do things the same way each time? _____

Become frustrated easily? _____

Have tantrums? _____ Hit/bite? _____

Describe any other behavior problems you have with your child: _____

Does your child have many friends? _____

Does he/she prefer to play with older children? _____ Younger children? _____ Alone? _____

What are your child's favorite play activities toys, games etc.?
_____

_____

Does your child have unusual fears? _____

Please check any terms that apply to your child:

_____Shy _____Friendly _____ Nervous _____ Cooperative _____ Creative _____ Thumb sucker _____Jealous _____ Nail biter

_____ Destructive _____Angry _____Aggressive _____Bites _____ Fidgety _____Daydreams _____Ritualistic _____ Rocks

_____ Head banger _____ Poor tolerance for change _____Avoids eye contact _____ Affectionate _____ Short attention span

_____ Lazy _____Overly active _____Absent minded _____Cuddler _____ Picky eater _____ Poor Appetite _____ Rarely shows emotions

Other: _____

Any Additional Concerns:

_____

_____

_____

Autism Treatment Center, Inc.
MEDICAL HISTORY QUESTIONNAIRE

Patient: _____ DOB: _____ Insurance ID#:_____

Education:
Current school placement: _____

Grade or class: _____

Does your child receive any form of special education?

_____

Describe any problems your child has had at school:
_____

_____

_____ _____
Patient Parent/Guardian Signature **Date**

_____ _____ _____
Therapist/Date **Therapist/Date** **Therapist/Date**

Patient Name: _____

Insurance #: _____

Autism Treatment Center, Inc.
CURRENT MEDICATION LIST

Patient Name:_____ ID number:_____

Allergies: ☐No Known Drug Allergies (NKDA) ☐Food Allergies: _____

☐Other:_____

Date	Medication	Dosage/Frequency/Route (oral, injection, topical)	Signature

Patient Name: _____

Insurance #: _____

AUTHORIZATION TO TRANSFER SERVICE PROVIDER

To Insurance Authorization Department:

REGARDING PATIENT:
_____DOB:____/____/____Ins.#_____

I, _____ (Patient Name), the undersigned, _____ (Patient/Guardian) understand that it is my right to select the treating provider. I have selected **Autism Treatment Center, Inc.** free of any undue pressure or solicitation by any officer, director, employee, or agent of the company to provide the therapy services. I have been advised by the company that I may request information concerning its scope of practice, services available and telephone numbers. I have been able to ask questions or express concerns which have been responded to by the company staff. I have been advised by the company that if for any reason I wish to change services to another provider, that I may do so at any time.

Patient Elected Transfer Statement

I, _____, the undersigned patient/guardian choose to transfer to **Autism Treatment Center, Inc.** from _____. The services they were providing were:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Effective transfer date: _____ Last Date of Service: _____

My Reason(s) for this request is:

☐ I believe I will be better served by this provider.

☐ I wish to be served by _____, therapist employed by this provider.

☐ Other (explain)_____.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Signature of Representative Date