6714 Winker Rd
Fort Myers, Fl 33919
Phone: 239-245-8301
Fax: 239-245-8731
Web: www.pxpinc.net
Email: info@pxpinc.net

Office Use Only

App Rec'd:____________

Paid Fee: ___________

Tour: _______________

Start Date: ____________

The attached packet of information will inform you about Peace By Piece and allow you time to gather information prior to your intake appointment with our staff. We understand the level of trust you are placing with us to assist you and your family. We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information that we have the better able we will be able to assist you and your family. If at any time in this process you have any questions please contact us.

We look forward to meeting you and your child,

Peace By Piece

What is required to Start Services?

1. Complete Insurance Information (if applicable)
2. Completed In-Take Packet

   - Intake Questionnaire
   - HIPPA Service Agreement and Consent Form
   - Patient Confidentiality Contact Form
   - Payment Policy Form
   - Request/Authorization to release Confidential Medical & Mental health Record and Information (Optional – as Needed)

3. In-Take Interview (1 hour)
4. Observations Completed
5. Assessments Completed
6. Meeting to develop treatment goals and program plan
7. Arrangement of Schedule

Confidential

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding your child. All information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines. Please use the backs of the pages for additional information.

ABA Intake Form

Child Information	
Last Name:	Age:
First Name:	Date of Birth:
Middle Name:	Gender:
	Social Security Number:
Home phone:	
Address:	
City:	
State: Zip code: Country:	

Primary Diagnosis:	Date of Diagnosis:
Other condition:	Date of Diagnosis:
Other condition:	Date of Diagnosis:

Mother or Legal Guardian Information	
Full Name:	Relationship to Child:
Address:(if different from applicant)	Social Security Number:
City:	Occupation:
State:	Name of Employer:
Home Phone: (if different from applicant)	Business Phone:
Cell Phone:	Fax:
Pager:	Email:

Father or Legal Guardian Information	
Full Name:	Relationship to Child:
Address:(if different from applicant)	Social Security Number:
City:	Occupation:
State:	Name of Employer:
Home Phone: (if different from applicant)	Business Phone:
Cell Phone:	Fax:
Pager:	E-mail:

Applicant's Siblings:		
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

Present School/Placement	
Name of School:	Years attended:
Address:	
Phone:	Placement:

Medical Information

Is your child on mediation? LI Yes LI No

If yes list medication administration times usage·

Type of Medication	Dosage	Administration Times	Used for

Additional medications can be attached an a separate sheet af paper and stapled to this intake.

Has the child ever been admitted to a hospital/treatment center for psychiatric, behavioral, or crisis situations? Ll Yes Ll No If yes, please explain.

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Please summarize the hospital/treatment facilities observation, treatment(s), and effectiveness of treatment(s).

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Are there any medical conditions that need to be considered when delivering ABA treatment?
Ll Yes Ll No If yes, please explain.

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____

____

History of Treatment	
LI Behavioral Consultation	Dates of service: ____ to ____________
Provider Agency:	
Provider Name:	
Provider Phone:	
Frequency of provider consultation:	

Methods of treatment by the provider.	
LI ABA Lovaas-based LI ABA Verbal Behavior-based LI TEACCH	LI Greenspan/Floortime LI RDI LI Other ____________

Please describe services by the provider and program information.

Please describe the results of these therapies in regards to success in achieving goals.

History of Treatment	
LI Behavioral Consultation	Dates of service: ____ to ____________
Provider Agency:	
Provider Name:	
Provider Phone:	
Frequency of provider consultation:	
Methods of treatment by the provider. LI ABA Lovaas-based LI ABA Verbal Behavior-based LI TEACCH	LI Greenspan/Floortime LI RDI LI Other ____________

Please describe services by the provider and program information.

Please describe the results of these therapies in regards to success in achieving goals.

Supportive Services

What other services is your child currently receiving both in-school and out of school? Please enclose a copy of the child's most recent IEP or IFSP and therapy goals from each area that is checked

Service/Therapy	Location		Minutes/Week
LI Early Intervention Services	LI School	LI Home	
LI Speech and/or language therapy	LI School	LI Home	
LI Occupational and/or Physical Therapy	LI School	LI Home	
LI Vision services in school	LI School	LI Home	
LI Hearing services	LI School	LI Home	
LI Other	LI School	LI Home	
LI Other	LI School	LI Home	

Please describe the results of these therapies in regards to success in achieving goals.

What, if any, behavior issues does your child have? Ex., self-injurious, aggressive towards others, etc., please explain. Include methods used to decrease these behaviors.

What are your immediate goals for your child?

What level of commitment are you willing to make at home in order for your child to achieve these goals?

What would you like us to know about your child?

What current communication skills does your child have? Ex., sign language, PECS, verbal, please explain

The undersigned hereby acknowledge that the information contained in this application is accurate in all respects.

Parent/Guardian (print name) ______________________________

Signature of PARENT/GUARDIAN: ______________________________

Date: ________________

Declaration of ProfessionalPractices andProcedures For Behavior Analysts

Dr. Renée M. Terrasi, PhD., BCBA-D

Board Certified Behavior Analyst - Doctoral

6714 Winkler Rd
Fort Myers, Fl 339019
239-245-8301

AREAS OF EXPERTISE

Dr. Terrasi has been practicing as a behavior analyst since 1997, as a teacher in the Lee County Public Schools. She received my PhD in Educational Leadership and Specialists in Special Education from Barry University; her Autism Specialist Certification from University of Massachusetts Lowell; her Masters Degree in Varying Exceptionalities from Florida Gulf Coast University and her Bachelors Degree in Elementary Education from Defiance College, Ohio.

PROFESSIONAL RELATIONSHIP, LIMITATIONS AND RISKS

What We Do

Behavior analysis is a unique method of treatment based on the idea that most important human behavior is learned over time and that it is currently maintained by consequences in the environment. Our job as behavior analysts is to work with behavior you would like to change. With your input, we can help you discover what is maintaining a behavior, discover more appropriate replacement behaviors, and then set up a plan to teach those behaviors. We can also develop a plan to help you acquire a new behavior or improve your skill level. Some of the time we will be treating you directly and at other times we may be training significant others as well.

How We Work

As behavior analysts, we do not make judgments about behavior. We try to understand behavior as an adaptive response (a way of coping) and suggest ways of adjusting and modifying behaviors to reduce pain and suffering and increase personal happiness and effectiveness.

You will be consulted at each step in the process. We will ask you about your goals, we will explain my assessment and the results of my assessment in plain English. We will describe my plan for intervention or treatment and ask for your approval of that plan. If at any point you want to terminate our relationship, we will cooperate fully.

Please know that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results. If we believe that my consultation has become non-productive, we will discuss terminating it and/or providing referral information as needed.

CLIENT RESPONSIBILITIES

I can only work with clients who fully inform me of any and all of their concerns. I will need your full cooperation as I try to understand the various behaviors that are problematic for you. I will be asking a lot of questions and making a few suggestions and I need your total honesty with me at all times. I will be showing you data as part of my ongoing evaluation of treatment and expect that you will attend to the data and give me your true appraisal of conditions.

One of the most unique aspects of behavior analysis as a form of treatment is that decisions are made based on objective data that are collected on a regular basis. I will need to take baseline data to first determine the nature and extent of the behavior problem that we are dealing with; then I will devise an intervention or treatment and continue to take data to determine if it is effective. I will show you this data and will make changes in treatment based on this data.

Under my code of ethical conduct I am not allowed to work with you in any other capacity except as your behavior therapist or consultant. If I am working in your home with your child it is not appropriate for you to leave the premises at any time or to ask me to take your child to some other location that is not directly related to my services.

I will need a list of any prescribed or over-the-counter medications and/or supplements in addition to any medical or mental health conditions; this information is kept confidential.

CODE OF CONDUCT

I assure that my services will be rendered in a professional and ethical manner consistent with accepted ethical standards. I am required to adhere to the GuidelinesforResponsibleConductof the Behavior Analyst Certification Board®. A copy of these Guidelines are available upon request.

If at any time and for any reason you are dissatisfied with our professional relationship, please let me know. If I am not able to resolve your concerns, you may report these to the following:Behavior Analyst Certification Board, Inc. • 1705 Metropollitan Boulevard, Suite 102 • Tallahassee, Florida 32308 850-386-4444 http://www.bacb.com/

CONFIDENTIALITY

In Florida, clients and their therapists have a confidential and privileged relationship. I do not disclose anything that is observed, discussed or related to clients. In addition, I limit the information that is recorded in your file to protect your privacy. I need you to be aware that the confidentiality has limitations as stipulated by law including the following:

- I have your written consent to release information.
- I am verbally directed by you to tell someone else situations.
- I determine that you are a danger to yourself or others.
- I have reasonable grounds to suspect abuse or neglect of a child, disabled adult, or an elder adult.
- I am ordered by a judge to disclose information.

______________________ Witness	______________________ Client
______________________ Date	______________________ Client

Service Agreement and Consent Form

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new client rights with regard to use and disclosure of your Protected Heath Information (PHI) used for the purpose of treatment, payment, and healthcare operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosesure of PHI for treatment, payment and healthcare operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

SERVICES OFFERED

We will provide services specifically designed to help you (and/or your minor child), or otherwise provide you with referrals to other professionals. Our behavioral services consist primarily of individual assessments, training, in-home, community and/or school consultations and observations, long term service provision to youth with developmental and neurological disabilities, and short-term consultations with individuals, parents, educators, and other related professionals.

APPOINTMENTS

Except for rare emergencies, we will see you (or your child) at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you speak to us personally and give us as much notice as possible to cancel or reschedule. This will allow us to offer your appointment time to another person. You may be charged the standard hourly rate for missed or cancelled appointments with less than 48 hours advance notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

PROFESSIONAL CONSULTATIONS

Behavior Analysts and Educators routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them. Unless you object, we do not typically tell clients about these consultations; however, these consultations will be so noted in your private health Information. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

RECORDS

We will review all testing results during our feedback session and offer you opportunities to review raw testing data with us. We will forward copies of any reports or written summaries to others only with specific, written consent from you. Because of the proprietary nature of testing materials, we will release raw data only to other appropriately credentialed professionals (except as otherwise required by law).

LEGAL PROCEEDINGS
If you are involved in a court proceeding and a request is made for information concerning our professional services, such information is protected

PAYMENT FOR SERVICES
If necessary, we may seek assistance from an outside party in order to collect payment for services rendered to you. In such cases, any disclosures are limited to the minimum that is necessary to achieve the purpose. As you might suspect, the laws and professional standards governing these issues are quite complex, and it is important that we discuss any questions or concerns that you (or your minor child) may have at our first meeting, and as they may arise in the course of our work together. If any of these types of situations arise, we will make every effort to fully discuss it with you before taking any action, and we will limit my disclosure to what is necessary. We are not attorneys, however, and you may wish to obtain formal legal consultation if you need specific advice.

WORK WITH MINOR CHILDREN
If a client is under eighteen years of age, the law may provide parents with the right to examine the minor child's records. Privacy, however is often crucial to successful progress in treatment and valid evaluation results If, in the course of an evaluation or consultation, a minor child reveals to us information that he or she does not want shared with his or her parents or guardian, we usually do not reveal such information unless we believe that there is a high risk that the minor will seriously harm him/herself or others, and in which case we will notify him or her of our intent to notify his/her parents or legal guardian(s).

TREATMENT PROCEDURES

Pre-Treatment
If the child has not had an ABLLS assessment conducted by a BCBA within the last 3 months, an ABLLS assessment will be required. Please submit all previous evaluations that have taken place in the past year. This assessment covers 25 areas of language and learning and is useful as a baseline for treatment as well as yearly follow-up for progress.

Evaluation of Treatment Effectiveness
The treatment protocol includes systematic and data-based instruction especially designed to meet each child's individual needs in the areas of learning readiness, attending, pre-academic and academic skills, self-care, social skills, language development, Functional Communication training, Mand training, and motor skills. The primary emphasis of teaching for children with autism will be working on communication and verbal skills. Behavioral methods such as natural environment teaching, natural language paradigms, analysis of verbal behavior, discrete trial teaching, precision teaching, and any other methods which have been scientifically documented to be effective for children with autism and related disorders in peer reviewed journals will be used for treatment of your child. Children with other diagnosis may work on higher-level cognitive goals; all treatment goals are individualized and based upon the child's learning strengths regardless of diagnosis.

Ongoing treatment evaluation is made possible by keeping all treatment and intervention data-based. Data-based treatment allows teachers, trainers, and parents to directly observe daily performance and collect data that provide feedback regarding treatment effectiveness and child progress. On the basis of these data, individualized programs will be revised as needed to allow the child's continued progress. Treatment goals will be divided into behavioral units. Behavioral units will be charted and graphed. Mastery criteria will be set for each behavioral unit. The behavioral unit will be targeted until the pre-determined mastery criteria are accomplished. Progress is determined and measured by the data collected at Peace by Piece. As long as the child is maintaining skills at 40-60% and gaining any new skills at 80-100%, he/she shall be determined to be

making adequate progress. Some children will have exceptions to this and this will be discussed with the parent. At any time, if the parent feels that the child is not progressing; concerns should be put in writing.

Treatment Reports and Additional time with the BCBA

Yearly ABLLS updates are free of charge. If you request an ABLLS more often than every year, the fee is $200 per update. Occasionally, parents request the BCBA to attend IEP meetings, phone conferences with other professionals, outside meetings, or additional paperwork. The BCBA will not attend any meetings for school districts without an invitation from the district. This type of service is only offered as available and is billed at the hourly rate. Preliminary paperwork for these meetings and services is also billed at the hourly rate hour.

Training Materials for Therapy Program

Parents are required to supply materials that are required for their child's specific training. Your child's therapist will inform you when you need to supply materials for your child. The Language Builder Cards are required and can be ordered from different Roads to Learning at www.difflearn.com or www.vbteachingtools.com. We strongly suggest that since some of our children have identical cards, that you take the time to label or stamp your child's cards with his/her name. You may also want to laminate them as well due to the high usage of these cards for the programs. We will not be responsible for your child tearing unlamented cards. You may purchase them or we can place an order for $135.00.

TEAM MEETINGS for Therapy Program

Team meetings consist of your child's therapist and Dr. Terrasi. These meetings are part of your child's program and will occur quarterly at Peace by Piece. Please contact the front office to schedule these meetings. If you would like to have more team meetings you may request those as well through the front office. The fee for additional meetings are $150.00 for 1 hour.

HEALTH CARE INSURANCE

If we do not file your insurance claim at the time of your appointment, we will provide you with statements that you may submit to your insurance carrier or complete any forms as required by your insurance carrier in order to obtain reimbursement for out-of-network providers. In order to assist you with obtaining reimbursement for our services, your insurance carrier may require that we provide a clinical diagnosis, or additional clinical information such as treatment plans or summaries, or copies of your child's entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Although all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report or form that we submit upon your request. By signing this Agreement, you agree that we can provide requested information to your carrier if/when you choose to file a claim for any services that we have provided to you for your child. Also be advised that many insurance plans do not pay for behavioral testing or significantly limit the amount of coverage they provide for this kind of service.

CONTACTING US

Given our many professional commitments, we are often not immediately available by telephone. If you need to leave us a message, we will make every effort to return your call promptly (within 24 hours) with the exception of holidays and weekends. If you are difficult to reach, please leave some times when you will be available. Because of the nature of the services we usually provide, WE DO NOT PROVIDE ON CALL COVERAGE 24 HOURS PER DAY, 7 days per week. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

PAYMENT POLICY

The hourly fee is per 50-minute hour for consultations, meetings, observations, report writing, and therapy. We charge this same fee on a prorated basis for telephone calls longer than five (5) minutes. Payment in full is due at the end of each appointment, except for testing, or within 15 days of receipt of monthly service invoices. For individual testing, however, we charge a flat fee for evaluations: $400 for a full ABLLS/VBMapp Assessment and Materials,$400 for a complete Functional Behavior Assessment An extensive amount of time is committed and required to provide this kind of service; therefore, we ask that 50% of this fee be paid as a deposit at the time o the appointment making arrangements for the testing sessions: the balance is due at the time of our meeting to review the report and address any questions. This fee/evaluation typically includes a review of records that you provide to us, an initial one-hour interview with the referral source (usually a parent or guardian in the case of the minor child), limited consultations with other professionals working with you or your child, testing, scoring, preparation of one comprehensive written report, and a one-hour feedback session and a follow-up phone call (of less than 30 minutes). Additional services such as any other consultative or therapeutic sessions, follow-up consultations with you or other parties (such as teachers, physicians, or other allied professionals), school observations (that may or may not be part of a more comprehensive evaluation), or preparation of any additional reports, will be charged at the appropriate hourly rate. We accept payment in the form of cash and checks. If, during the initial interview, the decision is made not to proceed with an evaluation, only the fee for the interview will be charged. In the unlikely event that you fail to pay us for services rendered and your account is more than 30 days past due, we may enlist the services of other persons or agencies to collect past-due amounts, and you will also be charged for any expenses so incurred.

CONSENT

Your signature(s) below indicates that you have read the information in this document and agree to abide by its terms, as well as indicating that you have received the HIPAA notice form described above. Consent by all parents/legal guardians (those with legal custody) is required.

____
Client or Child's Name

______________________________ ______________________________
Client or Child's Signature Date

______________________________ ______________________________
Parent/Guardian #1 name Parent/Guardian #2 name

______________________________ ______________________________
Parent/Guardian #1 Signature Parent/Guardian #2 Signature

*Please send completed form to:

Peace By Piece Solutions
6714 Winkler Rd
Fort Myers, Fl 33919

Include:

- D Copy of Insurance Card
- D Copy of most recent IEP/IFSP
- D Confidentiality Release Form
- D Copy of most resent comprehensive evaluations
- D Copy of most recent speech/occupational/physical therapy evaluations and goals
- D Videotape (25-30min) of your child during structured teaching if possible
- D A copy of completed ABLLS-R profile