SOUTH FLORIDA AUTISM CENTER INC.

CHILD INTAKE FORM

This form is designed to gather essential information before your initial appointment, ensuring a productive and efficient session. You are welcome to include any additional details that may help us better understand your child. SFA-Center treats all information provided as strictly confidential, releasing it only in accordance with HIPAA guidelines and legal requirements. This form must be completed by the patient's parent or legal guardian.

Client's Demographics:

Client's Name: _____

Today's Date:____/____/____ DOB: ____/____/____ Age: _____

Referred By: _____

Current Address:_____

Parent/Guardian's Name: _____

Parent/Guardian's Name: _____

Parent/Guardian's Phone Number: _____

Parent/Guardian's Phone Number: _____

Parent/Guardian's Email: _____

Parent/Guardian's Email: _____

Persons authorized to pick up the client:

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Nearest relative/neighbor to contact in case emergency contacts & parents cannot be reached:

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Client's Diagnosis:

Primary Diagnosis 1: _____
Diagnosis Date(s): _____
Diagnosing Professional: _____

Primary Diagnosis 2: _____
Diagnosis Date(s): _____
Diagnosing Professional: _____

Primary Diagnosis 3: _____
Diagnosis Date(s): _____
Diagnosing Professional: _____

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Allergies:

- ☐ No known allergies
- ☐ Foods:_____
  _____
- ☐ Medications:_____
  _____
- ☐ Environmental (ex. Insects, grass) _____
  _____
- ☐ Other:_____
  _____

Medication: List any medication the client is currently taking:
"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.

Name of Medication	Date Started	Reason for taking it	When it is given	Dose given	How it is given

Does your child have a history of therapies?

- ☐ Speech Therapy (ST)
- ☐ Occupational Therapy (OT)
- ☐ Physical Therapy (PT)
- ☐ Behavioral Therapy (ABA)
- ☐ Other:_____

Physician Information: (please fill this out in its entirety to ensure proper sending of documents) Referring Physician: _____

Office Name: _____

Phone Number: _____

Fax: _____

Address:_____

_____

Insurance/Payment Information:

Insurance Carrier: _____

Policyholder Name: _____

Plan Name: _____

ID Number: _____

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Educational History

Name of School/Daycare:_____

Address:_____

_____

Teacher's Name: _____

Does your child have an IEP? ___ Yes ___ No

Family History

The child lives with:

- ☐ Biological Parents
- ☐ Adoptive Parents
- ☐ Other: _____

Sibling Name: _____ Age ___

Sibling Name: _____ Age ___

Sibling Name: _____ Age ___

Does any family member have a history of any of the following:

- ☐ Speech Language Difficulties
- ☐ Learning Disabilities
- ☐ Other: _____

Languages spoken at home:

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Medical History:

Please indicate if your child has been diagnosed with any of the following medical diagnoses:

- ☐ Autism Disorder
- ☐ ADD/ADHD
- ☐ Learning Disability
- ☐ Other:_____

Was the child premature? ___ Yes ___ No

Any problems during or after birth? _____

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Please check if your child has any of the following disorders. If so, include the age of onset.

- ☐ Seizures _____
- ☐ Mumps _____
- ☐ Tonsillitis _____
- ☐ Diphtheria _____
- ☐ Meningitis _____
- ☐ Asthma _____
- ☐ High fevers _____
- ☐ Head injury _____
- ☐ Tuberculosis _____
- ☐ Enlarged glands ____
- ☐ Heart Issues _____
- ☐ Pneumonia _____
- ☐ Sinusitis _____
- ☐ Thyroid _____
- ☐ Diabetes _____
- ☐ Ear tubes ___

Please indicate milestones to the best of your ability:

Crawl _____ Walked _____ Toileted _____

Sat Up _____ Fed Self _____ Words _____

Stood _____ Dress Self _____ Phrases _____

Please describe if your child is experiencing issues in any of the following areas:

- ☐ Feeding
- ☐ Social with friends
- ☐ Academics
- ☐ Nightmares
- ☐ Anxiety
- ☐ Controlling temper
- ☐ Aggressive behavior
- ☐ Attention deficit
- ☐ Toileting

Does your child have hearing problems? ___ Yes ___ No

Does your child have a history of frequent ear infections?___ Yes ___ No

Does your child have vision problems? ___ Yes ___ No

Feeding/Eating History

Check all that apply:

- ☐ Thumb/finger sucking
- ☐ Pacifier use
- ☐ Difficulty nursing
- ☐ Reflux/coli
- ☐ Tongue thrust
- ☐ Messy eater
- ☐ Limited diet
- ☐ Food texture sensitivity
- ☐ Fine motor skills
- ☐ Drooling observed
- ☐ Tongue or lip tie present
- ☐ Food allergies
- ☐ Weight issues
- ☐ Picky eater
- ☐ Choking while eating
- ☐ Sensitive gag reflex

Is your child using a pacifier? ___ Yes ___ No

Is your child drinking out of a bottle with a nipple? ___ Yes ___ No

If so, how many times a day? _____

Does your child drink from: _____ Straw Cup ____ Sippy Cup ____ Open Cup

Is your child able to drink from a straw cup? ____ Yes ____ No

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Is your child eating the following food textures?:

- Pureed (yogurt, pudding, hummus) ___ Yes ___ No
- Mashed solids (Mashed avocado, mashed potatoes) ___ Yes ___ No
- Dissolvable solids (puffs, graham crackers) ___ Yes ___ No
- Soft solids (pancake, bread) ___ Yes ___ No
- Dense foods (peanut butter, soft fruits, pasta) ___ Yes ___ No
- Hard solids (nuts, raw veggies) ___ Yes ___ No
- Mixed texture (lasagne, salad) ___ Yes ___ No

Check all that apply:

- ☐ Bottle refusal as an infant
- ☐ Difficulty nursing
- ☐ Reflux/colic
- ☐ Tongue thrust
- ☐ Messy eater
- ☐ Limited diet
- ☐ Food texture sensitivity
- ☐ Tongue or lip tie present
- ☐ Food allergies
- ☐ Weight gain issues
- ☐ Released tongue/lip tie
- ☐ Choking while eating
- ☐ Sensitive gag reflex

Do you have concerns with your child's feeding abilities? Would you consider your child's diet to be limited (picky eater)? If so, please list your concerns:

_____

_____

Behavior

- ☐ Cries a lot
- ☐ Excitable
- ☐ Emotional
- ☐ Overactive
- ☐ Underactive
- ☐ Prefers to play alone
- ☐ Difficulty concentrating
- ☐ Serious
- ☐ Laughs easily
- ☐ Shy
- ☐ Friendly
- ☐ Fidgety
- ☐ Easily overwhelmed
- ☐ Tantrum
- ☐ Physically aggressive
- ☐ Verbally aggressive

Are there any concerns regarding behavior in the child's school or within the home? ___ Yes ___ No
If so, please elaborate:_____

_____

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Occupational

Does your child engage in eye-contact during communication? ___Yes ___No ___50% of the time

Does your child take off his/her own socks independently? ___Yes ___No ___Needs assistance

Does your child take off his/her own shoes independently? ___Yes ___No ___Needs assistance

Does your child take off his/her own pants independently? ___Yes ___No ___Needs assistance

Does your child take off his/her own shirt independently? ___Yes ___No ___Needs assistance

If your child is of school age, how would you describe his or her handwriting?___Good ___Fair ____Poor

When given a choice, does your child prefer to play alone or with others? ____Alone ____ Others

Speech/Language

Does your child communicate their wants and needs using words & word combinations?	__Yes	__No
Does your child have difficulty expressing their wants and needs (dragging you toward object as opposed to asking for it by saying "give me + object"?	__Yes	__No
Is your child's speech intelligible to unfamiliar listeners?	__Yes	__No
Do they stutter when they speak?	__Yes	__No
Does your child follow simple commands?	__Yes	__No
Does your child ask questions?	__Yes	__No
Does your child seem to understand what you are saying?	__Yes	__No
Does your child seem to learn new vocabulary every day?	__Yes	__No
Does your child respond to yes/no questions?	__Yes	__No
Does your child use: 1-2 word combinations?	__Yes	__No
Does your child use: 3-5 word combinations?	__Yes	__No
Does your child seem frustrated by speech difficulties?	__Yes	__No
Does your child play well with others?	__Yes	__No
Does your child seem to prefer to play alone?	__Yes	__No
Does your child seem frustrated by speech/language difficulties?	__Yes	__No
Does your child exhibit appropriate play skills?	__Yes	__No

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Provide examples of a typical sentence or utterance your child produces:

_____

_____

Describe as completely as possible your concerns about the child's speech or language problems:

_____

_____

_____

If the child is in school, are there any concerns about academic performance (reading, writing, subject areas?):

_____

_____

_____

Describe any concerns regarding hygiene skills (toileting, bathing, combing hair):

_____

_____

_____

Describe any concerns regarding feeding and eating skills (using utensils, drinking through a straw, food choices, ability to chew and swallow):

_____

_____

_____

Is there anything else about either your child's history or current condition that you feel is very important to mention:

_____

_____

_____

Problem Behavior Information:

Behaviors (physical aggression, verbal aggression, property destruction, tantrums, disrobing, self injurious behavior, eloping etc.)	**Frequency** (hourly, daily, weekly, less often, etc.)	**Duration** (how long does the behavior last)	**Behavioral Triggers**

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What situations are these behaviors MOST likely to occur? (Days/times/settings/activities/persons present)

_____

_____

What situations are these behaviors LEAST likely to occur? (Days/times/settings/activities/persons present)

_____

_____

What is the antecedent or what typically happens right BEFORE problem behavior occurs?

_____

_____

What typically happens right AFTER problem behavior occurs?

_____

_____

What current behavioral strategies or interventions are being implemented?

_____

_____

What behavioral strategies or interventions have been implemented in the past?

_____

_____

What does your child find reinforcing/motivates/interests your child?

_____

_____

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Routine & Sleep Schedule

Wakes up: _____ Lunchtime: _____

Arrives to school: _____ Nap-time: _____

Wake up from nap: _____

Pick up from school: _____

After school break down:_____

_____

Describe your child's hour before bedtime: _____

_____

What time does your child go to bed? Weekdays: _____ Weekends: _____

What time does your child wake up? Weekdays: _____ Weekends: _____

Does your child wake frequently during the night? ___Yes ___No

Child's Schedule

Please provide us with your child's current therapy and tutoring schedule, including the days and times, to help us avoid conflicts when scheduling the evaluation. If therapy is recommended, this information will also assist us in creating an appropriate therapy schedule. Additionally, if there are any other days or times you would like us to avoid for reasons unrelated to therapy or tutoring, please let us know.

Therapy: __ ABA __ Occupational Therapy __ Speech Therapy __ Physical Therapy __ Tutoring

Days/Time:

_____

Therapy: __ ABA __ Occupational Therapy __ Speech Therapy __ Physical Therapy __ Tutoring

Days/Time:

_____

Therapy: __ ABA __ Occupational Therapy __ Speech Therapy __ Physical Therapy __ Tutoring

Days/Time:

_____

Therapy: __ ABA __ Occupational Therapy __ Speech Therapy __ Physical Therapy __ Tutoring

Days/Time:

_____

Therapy: __ ABA __ Occupational Therapy __ Speech Therapy __ Physical Therapy __ Tutoring

Days/Time:

_____

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Teacher Questionnaire

Social Language Skills

Is the student social? Does he/she interact with peers during classroom activities?	Yes	No
Does the student initiate or respond to social interactions with others?	Yes	No
Does the student engage in group discussions or collaborative work (circle time)?	Yes	No
Does the student follow social rules (e.g., taking turns, sharing)?	Yes	No

Please list any concerns in this area:_____

_____

_____

Expressive Language Skills

Does the student express their thoughts, ideas, and needs verbally?	Yes	No
Does the student use complete sentences (or 2-3 word combinations if age appropriate) when speaking?	Yes	No
Do they demonstrate appropriate vocabulary for their age/grade level?	Yes	No
Are there any concerns with the student's ability to explain or describe things?	Yes	No

Please list any concerns in this area:_____

_____

_____

Receptive Language Skills

How well does the student follow verbal directions (single-step and multi-step)?	Yes	No
Do they understand classroom instructions without needing frequent repetition?	Yes	No
How well does the student comprehend stories, classroom discussions, or lessons?	Yes	No
Do they have trouble answering questions about things they've heard or read?	Yes	No

Please list any concerns in this area:_____

_____

_____

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Classroom Behavior

How often does the student stay focused and on task during individual or group activities?	Often	Rarely
Do they seem easily distracted or inattentive during lessons?	Yes	No
How does the student manage transitions between activities?	Yes	No
Are there any behavioral concerns (e.g., fidgeting, restlessness, lack of participation)?	Yes	No

Please list any concerns in this area:_____

_____

_____

Academic Concerns

Does the student complete their assignments independently and in a timely manner?	Yes	No
Are there any concerns regarding the quality of the student's work?	Yes	No
How does the student perform on assessments or classroom tests?	Good	Poor
Does the student participate in group activities (e.g., circle time, group projects)?	Yes	No

Please list any concerns in this area:_____

_____

_____

SOUTH FLORIDA AUTISM CENTER INC.

Authorization and Consent for Treatment, Payment, and Operations:

Please Initial the Following Statements:

_____ I have verified my insurance coverage before this therapy visit and confirm that I have obtained all necessary information regarding coverage limits, co-pays, and co-insurance.

_____ If paying out-of-pocket, I agree to pay for therapy sessions on a monthly basis. I understand that I can choose the number of sessions my child receives, regardless of the therapist's recommendations.

_____ I hereby authorize **South Florida Autism Center, Inc.** to evaluate and provide treatment for my child. I understand that this may involve written, oral, physical, and electronic communication between care providers, physicians, insurance companies, and **South Florida Autism Center, Inc.** staff. Additionally, I acknowledge that state representatives may review my child's records for insurance certification, licensing, and quality assurance purposes. All confidentiality protocols will be followed in the use of this information.

_____ I authorize **South Florida Autism Center, Inc.** to submit claims directly to my insurance provider. *(Please disregard this statement if paying out-of-pocket.)*

My signature below signifies that I have read, understood, and agree to the **Authorization and Consent for Treatment, Payment, and Operations**.

Signature of Parent/Guardian: _____ **Date:___/___/_____**

Financial Policy:

South Florida Autism Center, Inc. is committed to providing the highest quality care. To ensure continued services, we ask that you carefully review and adhere to our financial policy:

- Payment, co-pays, deductibles, and co-insurance for services are due at each visit for charges incurred up to the last visit. We accept **cash, checks, and credit/debit card payments**.
- You are financially responsible for all charges, **regardless of insurance payment status**.
- **Insurance Disclaimer:** Your insurance contract is an agreement between you (or your employer) and your insurance provider. **South Florida Autism Center, Inc.** is not a party to this contract. While we will bill your insurance provider as a courtesy, we cannot guarantee timely payment. **If a claim is not paid within 60 days, you agree to arrange prompt payment.**
- If your insurance coverage is terminated, you must inform **South Florida Autism Center, Inc.** immediately. Failure to notify us in advance will result in full financial responsibility for any services rendered after your coverage expires.
- **Copays and coinsurance must be paid at the time of service.**
- Not all services are covered by all insurance plans. Certain services may be denied by your provider, in which case **you will be responsible for those charges**.
- If financial obligations are not met, your child may be discharged from therapy.

We understand that financial difficulties may arise. If you experience financial hardship, we encourage you to contact our billing department to discuss payment arrangements.

My signature below signifies that I have read, understood, and agree to the **Financial Policy**.

Signature of Parent/Guardian: _____ **Date:___/___/_____**

SOUTH FLORIDA AUTISM CENTER INC.

Cancellation Policy:

Attending scheduled appointments is essential for your child's progress. Missed or last-minute cancellations disrupt the treatment process and affect other families.

Please review our cancellation policy:

- **We require at least 24 hours notice for all cancellations.**
- **No-Show Policy:** If you have **two no-shows** within a four-week period (missed appointments without prior notice), your child may be discharged from therapy, and your physician will be notified.
- **Frequent Cancellations:** If you cancel **three appointments** in a four-week period, your child may be discharged from therapy, and your physician will be notified. (Each case will be reviewed individually.)
- Families are able to **reschedule missed appointments** whenever possible.
    - Rescheduling is **subject to therapist and schedule availability**.
    - Please contact us as early as possible to explore available time slots.
    - Rescheduled sessions help maintain treatment consistency and support your child's progress.

We understand that emergencies arise. Excused absences include illness, doctor's appointments, pre-planned vacations, or school activities with advance notice.

My signature below signifies that I have read, understood, and agree to the **Cancellation Policy**.

Signature of Parent/Guardian: _____ **Date:___/___/_____**

HIPAA Notice of Privacy Practices

This **Notice of Privacy Practices** explains how we use and disclose **Protected Health Information (PHI)** in accordance with federal law. PHI includes information that identifies your child and relates to their health condition or treatment.

How We Use and Disclose PHI:

- **Treatment:** We may share PHI with healthcare providers, specialists, or agencies involved in your child's care.
- **Payment:** PHI may be used to process insurance claims, obtain authorizations, and verify coverage.
- **Healthcare Operations:** PHI may be used for quality assurance, accreditation, compliance, and administrative purposes.

Your Rights Under HIPAA:

- You may **request restrictions** on how we use and disclose PHI.
- You may **request confidential communications** (e.g., using an alternative address or phone number).
- You may **request a paper copy** of this notice at any time.

Filing Complaints:

If you believe your privacy rights have been violated, you have the right to file a complaint with **South Florida Autism Center, Inc.**. We will not retaliate against you for filing a complaint.

If you have any questions about your privacy rights, please contact us. Our goal is to provide the highest level of service while maintaining the confidentiality of your child's health information.

Signature of Parent/Guardian: _____ **Date:___/___/_____**

SOUTH FLORIDA AUTISM CENTER INC.

Photo/Video Release

South Florida Autism Center, Inc. is pleased to engage with our community through social media platforms such as Instagram and our website. These platforms allow us to share office updates, staff highlights, and other valuable information that may benefit our patients and their families.

With explicit permission from our patients and their caregivers, we may share:

- Welcome posts for new patients
- Photos of patients participating in therapy activities
- Celebratory posts for patients reaching therapy milestones
- Other therapy-related content

Consent Selection

Please sign next to one of the following options:

✔ **I, _____, give my consent** for my/my child's photos to be shared on social media platforms.

✘ **I, _____, do not give my consent** for my/my child's photos to be shared on social media platforms.

By signing below, I acknowledge that I have read, understood, and agreed to the items outlined in this document.

Signature of Parent/Guardian: _____ **Date:**___/___/_____

Please complete and return this form to **therapy@sfa-center.org** prior to your child's initial appointment.

SOUTH FLORIDA AUTISM CENTER INC.

Clinic Policies

To ensure the safety and smooth operation of our therapy sessions, please review and follow the clinic procedures below:

- Upon arrival, **please sign in at the front desk**.
- Our front office staff will notify your child's therapist when you've arrived.
- **You must remain with your child in the waiting area until the therapist comes to pick them up.**
- **Please return to the lobby at least 5 minutes before the session ends** to ensure a timely pickup.
- If you would like to speak with your child's therapist about the session or progress, **please use our Remind App** to communicate, as therapists are often scheduled back-to-back.

Remind App

SFA-Center uses the **Remind App** to streamline communication between parents and therapists. This allows for secure, timely updates without disrupting therapy sessions.

How to Join:

1. **Download the Remind App** from your phone's app store.
2. **Create an account**, and be sure to include your name along with your child's name in the display name.
    - Example: *Thalia – Timmy J.'s Mom*

3. **Check your email**: You will receive a message with a class code and instructions on how to join the **Therapy Remind Class** prior to your child's first session.

Using the Remind App helps us keep you informed while respecting our therapists' time with their clients. Please give your therapist 24hrs to respond to your message on remind. Thank you for your cooperation!

SOUTH FLORIDA AUTISM CENTER INC.

DOCUMENTS REQUIRED

In addition to the intake form filled out, please email us the following documents

- ☐ Your child's insurance card
- ☐ A doctor's referral for speech, occupational therapy
- ☐ Your driver's license

Additionally, if your child is transferring from another clinic, please submit the following:

- ☐ Discharge from previous clinic
- ☐ Evaluation & plan of care, if conducted within the last six months

The clinic details are as follows:
South Florida Autism Center Inc.
Address: 3751 W 108th Street, Hialeah FL 33015
EIN: 47-3854048
NPI: 1245685627
Email: therapy@sfa-center.org