Therapy Pre-Enrollment Form

Thank you for taking the time to complete this form. This information will be uploaded to our electronic database. Our front-office administrator will be in contact with you to verify receipt of the document and gather any additional information that may be needed. Please fax this form to 763-328-2782 or email intake@autismmatters.net. If you have any questions, please contact your location of interest.

Personal Information

Have you received services from us in the past? ❑ Yes ❑ No

Preferred Language: ____________________________ Do you need an interpreter? ❑ Yes ❑ No

First and last name:_________________________________ Date of Birth:__________________________

Mailing address:____

Email Address:_______________________________________ Phone:____________________________

Gender: ❑ Male ❑ Female ❑ Other:____________ Preferred Pronouns: __________________

Legal Guardian 1 (Only required for client's under the age of 18)

Name:____Relationship to child:____________________

Phone: ___________________________________ Email: ____

Preferred Communication Method: ❑ Email ❑ Phone

Legal Guardian 2

Name:____Relationship to child:____________________

Phone: ___________________________________ Email: ____

Preferred Communication Method: ❑ Email ❑ Phone

Insurance Information

First and last name of primary subscriber:_______________________________ DOB of primary subscriber:____________

Primary insurance name:____________________________ Primary insurance ID # on card:__________________________

Primary insurance group #:__________________________ Effective Date: __________

First and last name of subscriber on secondary insurance: ____

Secondary insurance name:__________________________ Secondary insurance ID # on card:________________________

Secondary insurance group #:_________________________ Effective Date:_______________________________________

Marketing and Referral Information

How did you hear about us? ____

Referring Doctor/Physician:____

Phone number:_______________________________________ Fax number: ____

Mailing address:____

Primary Care Provider: ____

Phone number:_______________________________________ Fax number: ____

Mailing address:____

 INTERNAL USE: Date Paperwork Received ________________

Service Information

What location(s) is preferred?

- ❑ Rogers ❑ Cambridge ❑ Baxter ❑ Plymouth

What services are you interested in receiving? (check all that apply)

- ❑ ABA Therapy ❑ Speech-Language Therapy ❑ Occupational Therapy
- ❑ Feeding Therapy ❑ Psychotherapy – Family ❑ Psychotherapy – Individual

If seeking ABA Therapy, would you be interested in beginning Outpatient Services prior to ABA, if possible?
❑ Yes ❑ No

Diagnostic Assessment (DA) completed? ❑ Yes ❑ No Date completed: ____________________
Date of last Comprehensive Multi-Disciplinary Evaluation (CMDE), if applicable: ________________________________

Current services within the last 12 months, if applicable:

- ❑ ABA Therapy ❑ Speech-Language Therapy ❑ Occupational Therapy
- ❑ Feeding Therapy ❑ Psychotherapy ❑ Other:______________________________

Please list the service name and location(s): ____

List 3 of your most preferred items:
____

What domains do you and/or your child face difficulties in?

- ❑ Communication ❑ Daily Living Skills ❑ Maladaptive Behaviors (attention, aggression, etc)
- ❑ Relationships ❑ Gross Motor ❑ Fine Motor ❑ Eating/Feeding
- ❑ Sensory ❑ Safety ❑ Emotional Regulation ❑ Play ❑ Other:_______

Availability

To assist us in ensuring that we can provide the level of intensity that you and/or your child requires, as determined through assessment, please provide us with a schedule below of availability for services. Our hours of operations are Monday-Friday, 8am-5pm CST.

Week Days	Time of Day Available (document all times available)	Time of Day Not Available for Services
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

INTERNAL USE: Date Paperwork Received _______________