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:_____

If you or your child are seeking psychotherapy services, what specific goals or outcomes are you hoping to achieve through therapy, and what difficulties or obstacles are you currently facing?

_____

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		