2026

New Client Intake Packet

ABA Therapy Services

In-Home, In-Clinic, In-Community

www.Autismrcenter.com

Welcome and thank you for selecting ARC as your Applied Behavior Analysis (ABA) service provider. We look forward to helping you and your family meet your goals. It is the mission of ARC to provide compassionate, person-centered behavioral therapy to individuals in an outpatient setting so they can learn the skills necessary to succeed. ARC uses Applied Behavior Analysis as a practical and efficient treatment approach to assist individua ls and their families in improving quality of life and positive family dynamics.

At ARC, our Philosophy of Treatment is very important to us. We believe it is essential to the success of our clients that all treatment be provided in a manner consistent with this philosophy. As such, we continuously strive to ensure our therapeutic interventions:

- Be individualized and person-centered.
- Target meaningful skills that will improve the overall quality of the individual's life.
- Be implemented by well-trained and knowledgeable professionals.
- Be provided in a manner that is fun and rewarding for the child.
- Occur in collaboration with other treatment professionals to ensure the success of the child.
- Be based on findings established from rigorous scientific research.

The new client paperwork that you will be completing will help familiarize you with our policies and procedures regarding our ABA services. Additionally, the information you provide in this packet will help us in getting to know you and your child. Furthermore, the information will assist us in planning and designing a highly customized ABA program for your child. Therefore, we ask that you please take your time to review the information in this packet and to answer each question as thoroughly as possible.

At ARC, we would like to take this opportunity to thank you for entrusting us in providing services to you and your family. ABA treatment is about teamwork, and we value you as part of the team, therefore, if at any time in this process you have any questions please feel free to contact one of our staff in the office and we will be glad to help you.

Thank you again and we look forward to this journey with you and your child!

Sincerely,
Sanaz Pasha

Section 1: General Information

Client Full Name: _____
Date of Birth:
Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say
Primary Language: _____
Secondary Language (if any): _____
Address: _____
Phone Number: _____ Email: _____
Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Parent/Guardian #1 Name: _____
Relationship to Client: _____
Phone Number: _____

Parent/Guardian #2 Name (if applicable): _____
Relationship to Client: _____
Phone Number: _____

Custody Arrangement (If applicable): _____
Court Ordered? Yes ☐ No ☐

Section 2: Insurance & Provider Information

Primary Insurance Provider: _____
Member ID: _____ Group #: _____
Policy Holder Name: _____ Relationship: _____
Policy Holder DOB: _____

Secondary Insurance Provider (if applicable): _____
Member ID: _____ Group #: _____

Referring Physician Name: _____
NPI #: _____
Phone Number: _____
Diagnosis (if known): _____
Date of Diagnosis: _____

Section 3: Family & Cultural Information
Are there cultural, religious, or personal beliefs we should be aware of in your child's care?
☐ Yes ☐ No
If yes, please describe:

Does your family participate in any cultural traditions that are important for your child?
☐ **Yes** ☐ **No**
If yes, please describe:

What are your child's strengths and favorite activities?

What are your family goals for ABA therapy?

What are the guardian(s)'s occupations?

Does either parent/guardian's job require him/her to be away from home for long hours or extended periods of time that might prevent them from being involved in ABA services and parent training?

Section 4: Medical History
Medical Provider Information
Primary Care Physician: _____
Phone Number: _____
Specialists (e.g., Neurology, GI, Psychiatry):

Medical Diagnoses (check all that apply)
☐ Autism Spectrum Disorder
☐ Intellectual Disability
☐ Seizure Disorder
☐ ADHD
☐ Asthma
☐ GI Issues
☐ Sleep Disorder

☐ Allergies (list below)
☐ Other: _____

Allergies (food, medication, environmental):

Medications (list all current medications):

Medication Dose Frequency Prescribing Doctor:

Section 5: Birth & Developmental History
(Pregnancy and Birth History – complications, hospital stay, birth weight, birth week/full term).

(Developmental Milestones - age when achieved sitting up, walking, standing, first word, toileting, etc.)

History of Hospitalizations, Surgeries, and any other Medical Events:
(History of medical issues, infections, trauma, etc.)

Vision and Hearing: Any history of vision or hearing issues? Date of last exam? Results?

History of Mental Health Challenges:
(History of anxiety, depression, and emotional difficulties? History of mental health services? Any known history of trauma or abuse?)

Section: Educational Background
Previous Education (previous schools, previous services such as speech therapy, behavior plans, etc.)

Current Education (current grade, current school, special education services (IEP, 504), general education classroom, services provided such as speech therapy, occupational therapy).

Current Services (check all that apply):
☐ ABA Therapy
☐ Occupational Therapy (OT)
☐ Speech Therapy
☐ Physical Therapy (PT)
☐ Counseling/Psychotherapy
☐ Other: _____

Section : Behavioral Concerns:
(What are the primary behavioral concerns?)

Challenging Behaviors Observed (check all that apply):
☐ Aggression (hitting, biting, kicking etc.)
☐ Self-injury
☐ Tantrums
☐ Property destruction (includes throwing items, kicking walls, smashing objects, etc)

☐ Elopement (from room, building, or surrounding areas)
☐ Task-refusal (difficulty completing tasks, protesting to complete any or certain tasks)
☐ Stereotypy (repetitive behaviors – vocal, physical, etc)
☐ Other: _____

Settings where behaviors occur most often:
☐ Home ☐ School ☐ Community ☐ Therapy

What strategies have you tried to manage these behaviors?

_____
_____
_____
_____

What seems to trigger these behaviors?

_____
_____
_____
_____

What helps the behavior in the moment?

_____
_____
_____
_____

Section 7: Communication & Social Skills

Current Communication Method(s):
☐ Verbal
☐ Sign Language
☐ Picture Exchange (PECS)
☐ Device (AAC)
☐ Gestures
☐ Other: _____

Able to express wants and needs? ☐ Yes ☐ No
Understood by others? ☐ Always ☐ Sometimes ☐ Rarely
Social Engagement with Others:
☐ Engages with peers

☐ Parallel play only
☐ Avoids others
☐ Initiates social interaction

Section 8: Educational Background

Current School Name: _____
Grade Level: _____
Special Education Services (IEP/504)? ☐ Yes ☐ No
If yes, what services are provided (e.g., speech, OT, PT)?

_____
_____
_____
_____
_____

Mainstreamed or Special Education Classroom:
☐ Mainstream ☐ Self-contained ☐ Mixed

Previous Schools/Programs Attended (Please provide the same information as above for previous schools):

_____
_____
_____
_____
_____

Section 9: Therapy & Support Services

Current or Previous Services (check all that apply):
☐ ABA Therapy
☐ Occupational Therapy (OT)
☐ Speech Therapy
☐ Physical Therapy (PT)
☐ Counseling/Psychotherapy
☐ Other: _____

Provider(s):

_____
_____
_____
_____
_____

Section 10: Goals for ABA Therapy

What are your primary goals for ABA therapy? (Check all that apply)
☐ Improve communication
☐ Reduce challenging behavior
☐ Increase social skills
☐ Increase independence
☐ Toilet training
☐ Academic readiness
☐ Community skills
☐ Other: _____

Please describe any specific goals you have in mind:

_____
_____
_____
_____
_____

Section 11: Consent and Signature

I certify that the information provided is accurate to the best of my knowledge. I understand that this information will be used for treatment planning and may be shared with insurance providers as necessary for authorization of services.

Signature (Parent/Guardian): _____
Date: _____

📘 Parent Rules & Expectations Handbook

🩹 Purpose of This Handbook

This handbook is designed to ensure that all ABA services are delivered in a safe, effective, and ethical manner. It outlines expectations for families and caregivers to help create a productive partnership with your ABA team.

✅ 1. Guardian Presence Requirement

- A **parent, guardian, or responsible adult (18+)** must be present **at all times** during ABA sessions.
- This ensures:
  - Client safety
  - Effective behavior management
  - Immediate access for team communication
- If no adult is present, **services may be cancelled** or paused until supervision is restored.

🧯 2. Safety & Environment

- Please ensure the therapy environment is:
  - **Free of hazards** (e.g., exposed wires, unlocked chemicals, sharp objects)
  - **Minimally distracting**
  - Equipped with a **clear space for work and play**
- Pets must be kept in another area during sessions unless previously approved.
- Weapons or firearms must be **secured and locked away** during services.

🧑 3. Participation in Treatment

- Parents/guardians are expected to:

- Attend **team meetings** (e.g., treatment plan reviews, monthly check-ins)
- Participate in **parent training**
- Be open to learning and implementing ABA strategies

🕑 4. Attendance & Cancellations

- Notify the provider **at least 24 hours in advance** for cancellations when possible.
- Excessive absences (typically >10% of scheduled hours) may lead to:
  - A revision of the treatment plan
  - Potential loss of authorized hours

📜 5. Insurance Compliance

- Parents must:
  - Submit all required intake and documentation forms
  - Notify the provider of **insurance changes** (new provider, policy #, etc.)
  - Cooperate with reauthorization and medical necessity processes

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📱 6. Communication & Professional Boundaries

- Communicate questions or concerns directly with the BCBA (supervising behavior analyst).
- Do not request services outside of scheduled sessions.
- Do not ask staff to:
  - Babysit
  - Perform personal errands
  - Transport clients
- Maintain respectful communication with all staff at all times.

🧼 7. Hygiene & Health Policies

- Please cancel if your child:
    - Has a **fever**, contagious illness, vomiting, or diarrhea. Please do not resume services until these symptoms have been gone for 24 hours WITHOUT medication.
    - Has been diagnosed with a condition requiring quarantine (e.g., flu, COVID-19)
- All staff will follow proper hygiene (e.g., handwashing, cleaning materials). Please ensure your child is clean and dressed for each session.

📋 8. Data Collection & Observations

- Therapists will collect data throughout each session.
- You may observe sessions occasionally, but please minimize interruptions unless previously arranged with the BCBA.

📑 9. Confidentiality

- All client information is protected under HIPAA.
- Staff will never share client details outside the treatment team or without written consent.

❗ 10. Emergency Protocol

In the event of an emergency:

- Staff will follow the agency crisis protocols.
- You will be contacted immediately.
- Please ensure **up-to-date emergency contacts** are on file.

📄 Acknowledgement

I have reviewed and understand the policies outlined in this handbook. I agree to abide by the expectations and safety procedures to support the success of ABA services for my child.

Parent/Guardian Name: _____

Signature: _____

Date: _____

Parent Guide Cheat Sheet for ABA Services

📘 What Is ABA (Applied Behavior Analysis)?

ABA is a therapy based on the science of learning and behavior. It helps children:

- Improve communication and social skills.
- Reduce challenging behaviors.
- Increase independence.
- Learn new daily living skills.

ABA breaks skills into small, teachable steps and uses **positive reinforcement** to build helpful behaviors.

🔑 Key ABA Terms to Know

Term	What It Means
Antecedent	What happens before a behavior (the trigger).
Behavior	What the child does (the action).
Consequence	What happens after the behavior (the result).
Reinforcement	A reward or response that increases the behavior happening again.
Prompting	Helping your child do a skill (like a hint or nudge).
Fading	Slowly reducing help so the child learns to do it alone.
Extinction	Stopping reinforcement for unwanted behavior to reduce it over time.
Replacement Behavior	A positive/preferred behavior taught instead of a challenging one.

⭐ What ABA Might Work On

- **Communication:** Requesting, labelling, making choices.
- **Social Skills:** Sharing, turn-taking, greetings.

- **Daily Living:** Toileting, dressing, brushing teeth.
- **Emotional Regulation:** Identifying emotions, using coping strategies.
- **Behavior Management:** Reducing tantrums, aggression, or noncompliance.
- **School Readiness:** Sitting, following directions, attending to tasks.

🧩 Common ABA Strategies Used

Strategy	How It Helps
Discrete Trial Training (DTT)	Structured teaching using quick, repeated trials.
Natural Environment Teaching (NET)	Teaching during play or real-life routines.
Task Analysis	Breaking a big skill into small, teachable steps.
Visual Supports	Using pictures to help with understanding and routines.
Token Systems	Earning tokens or points toward a reward.
Behavior Plans	Plans for how to respond to behaviors and what to teach instead.

👨‍👩‍👧 How Parents Can Support ABA at Home

✅ Use consistent language.

✅ Follow through with instructions.

✅ Reinforce positive behavior (praise, high-fives, rewards).

✅ Communicate with your ABA team.

✅ Ask questions and attend parent training.

✅ Practice skills outside of therapy (in natural routines).

🔄 Example at Home: Reinforcement

Instead of:

"If you don’t clean up, you won’t get the tablet!"

Try:

"First clean up, then you get the tablet!"

(Predictable + positive = powerful!)

💬 **Questions to Ask Your ABA Provider**

- What goals are you working on with my child?
- What can I do at home to support these goals?
- How will you measure progress?
- What strategies are being used for challenging behavior?
- How can I be involved in my child’s therapy?

💔 **Remember:**

Consistency is key. Progress takes time. Celebrate the small wins. Your involvement matters!

AUTISM
Reimagined Center

AUTHORIZATION FOR MUTUAL EXCHANGE OF INFORMATION

This authorization allows the provider(s) named below to release confidential information and reports. (Note: Information and records regarding minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules (CFR 42 part 2) that require specific authorizations).

I hereby authorize (enter information of disclosing party): _____

Please complete the following sections to indicate the names of the providers you would like to be used for our release of information form

Diagnosing Doctor:

_____

Provider Name(s)/Office(s)

Primary Care Provider:

_____

Provider Name/Office

School District:

_____

School Name/Teacher Name/ District/ Classroom Assistant Names

Therapies current and/or received within the past two years (Speech, OT, PT...etc.):

_____

Provider Name(s)/Office(s)

Any Additional Providers (Psychologist, Medication Management... etc.):

year round allergy medication

_____

Provider Name/Office & What services they are for

_____

Provider Name/Office & What services they are for

_____

Provider Name/Office & What services they are for

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I hereby authorize (enter information of disclosing party):

_____
Name/Role

_____
Address

_____
City / State / Zip Code

_____
Phone

_____
Fax

To release the information requested below, by means of mail, fax or other electronic methods, To: Autism Reimagined Center, Please send records to: fax: (571) 597-1199, address: Autism Reimagined Center, 10640 page Ave. Suite 440, Fairfax, VA 22030

This authorization is:
{____} Unlimited (all records)_____
{____} Limited to the following information:_____

For the purpose of: _____

This authorization shall be effective immediately and remain in effect until terminated by me in writing.

I understand that by signing this authorization:

• I understand that my treatment records are protected under the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, NAC 641.224, NRS 641.00,, and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

• I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.

• I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.

• I have the right to receive a copy of this authorization.

• I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

• I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

_____ _____

Signature of Patient/Guardian/Legal Representative Relationship (if other than Patient)

_____ _____

Patient's Name (PRINT) Date of Authorization

_____

Patient's Date of Birth

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