SOUTHEAST MISSOURI
STATE UNIVERSITY · 1873

Dear Parent/Guardian,

Thank you for inquiring into the services available at the Southeast Missouri State University Autism Center for Diagnosis and Treatment. In order for us to evaluate the needs of your child, we are asking that you complete the enclosed paperwork. This paperwork will allow us to assess your concerns and to further understand the services you are seeking.

Contained in this packet are forms to be filled out about your child's developmental and medical history. Once we have received your completed packet, our clinical team will review the information you have provided to us. If the Southeast Missouri State University Autism Center for Diagnosis and Treatment is the appropriate place to evaluate and/or treat your child, you will be contacted to schedule an appointment. If our center is not the best place for your child, we will assist you in contacting an appropriate specialist to schedule an appointment. We will not be able to determine the appropriateness of a referral until we have all of the documents returned to the center.

We will call you to schedule an appointment once the packet and insurance information are received back in our office and an appointment becomes available. Families are called in the order in which their paperwork is received.

We understand you will be sharing sensitive information and want to assure you we will follow HIPAA procedures for maintaining confidentiality. A copy of our HIPAA privacy practices is enclosed. As part of our ability to determine whether our services are appropriate, we will need access to reports from past evaluations and/or services such as psychological, educational, speech therapy, occupational therapy, behavioral programming, medical or other relevant information. Please return the appropriate signed releases and forms with your packet.

Further information regarding services can be found on our website:
http://www.semo.edu/autismcenter/.

Should you have any questions regarding the packet, please feel free to contact our office at 573-986-4985.

Intake Services
Southeast Missouri State University Autism Center
(573) 986-4985

Clinical Staff:

Dr. M. Renee Patrick
Director
Licensed Clinical Psychologist

Carly Beckett
Psychologist

Denise McQuerter
Licensed Professional Counselor

G. Elaine Beussink
Speech Language Pathologist

Erica Welter
Speech Language Pathologist

Allie Bruner
Board Certified Behavior Analyst

Ashten Ozbun
Board Certified Behavior Analyst

Andrea VanHorn
Board Certified Behavior Analyst

Documentation Checklist

We have provided this sheet for you to use as a checklist to help with returning your paperwork. All documents in **BOLD** must be returned before we can schedule an appointment. If you have any questions, please call our office.

- ☐ Packet Information Letter
- ☐ Documentation Checklist
- ☐ **Acknowledgement of HIPAA Privacy Practices**
- ☐ **Custody Agreement/Guardianship Papers/Adoption Papers (If not biological parent)**
- ☐ **Client History Form**
- ☐ **Treatment Consent Form**
- ☐ **Appointment Cancellation Policy**
- ☐ **Duplication of Services**
- ☐ **Media Release and Student Training Form**
- ☐ **Patient Registration Form**
- ☐ **Insurance Authorizations and Billing Information**
- ☐ **Copy of all insurance cards (Front and Back)**
- ☐ **Telehealth Consent**
- ☐ **Authorization to Use or Disclose Information**
  - ☐ **Pediatrician/Family Doctor**
  - ☐ **School/Early Childhood Services**
- ☐ Reports from previous evaluations and/or services
  - ☐ Psychological evaluations
  - ☐ Educational evaluations
  - ☐ Speech therapy/occupational therapy
  - ☐ Behavioral programming
  - ☐ Medical
  - ☐ Other relevant information

SOUTHEAST MISSOURI STATE UNIVERSITY · 1873
Autism Center for Diagnosis and Treatment

AUTISM CENTER FOR DIAGNOSIS AND TREATMENT
One University Plaza, MS 9450
Cape Girardeau, Missouri 63701

573.986.4985 Phone
573.986.4994 Fax
autismcenter@semo.edu
semo.edu/autismcenter

Acknowledgement of HIPAA Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out our services to you/your program consumer, and for other purposes that are permitted or required by law. "Protected health information" is information about you/your consumer, including demographic information, that may identify you/your consumer and that relates to you/your consumers past, present or future physical or mental health or condition and related health care services. Please read carefully.

Clinic Operations: We may use or disclose, as-needed, your protected health information in order to conduct our business activities here at the clinic. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to supervised student interns from Southeast Missouri State University who work with consumers here at the Southeast Missouri State University Autism Center for Diagnosis and Treatment. We will not disclose protected health information to any other party without a release form signed by a parent/guardian.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law; communicable diseases; health oversight; abuse or neglect; food and drug administration requirements; and legal proceedings.

Your Consumer Rights:
Following is a statement of your consumer rights with respect to your protected health information.

You have the right to request a restriction of your protected health information. This means you may request that any part of your PHI (protected health information) not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply, and must be submitted in written form.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI (protected health information).

Complaints:
You may complain to the Director, the University Privacy Officer, or to the Office of the Provost if you believe your privacy rights have been violated by this organization.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 573-651-2063.

Signature below is only acknowledgement that you have received the Notice of Privacy Practices:

Client Name: _____ Date: _____

Signature of Client or Representative: _____

We reserve the right to change the terms of this notice and will inform you of any changes. You may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of your next appointment. You then have the right to object or withdraw as provided in this notice.

SOUTHEAST MISSOURI
STATE UNIVERSITY · 1873
Autism Center for
Diagnosis and Treatment

AUTISM CENTER FOR DIAGNOSIS AND TREATMENT
One University Plaza, MS 9450
Cape Girardeau, Missouri 63701

573.986.4985 Phone
573.986.4994 Fax
autismcenter@semo.edu
semo.edu/autismcenter

Client History

Name of Client _____

Date of birth ____/____/____ Age_____ Sex _____

Address of Client _____

City _____ State _____ Zip _____

County _____ Home Phone (____) _____

Work/Cell Phone (____) _____ Email _____

Okay to leave a message at Work/Cell #? ____Yes ____No Home#? ____Yes ____No

Parent, Guardian, or Spouse (if applicable) _____

Address _____ City _____ State____ Zip _____

County _____ Home Phone (____) _____

Work/Cell Phone (____) _____ Email _____

Okay to leave a message at Work/Cell #? ____**Yes** ____**No** Home#? ____**Yes** ____**No**

Who referred you to the Autism Center (referral source)?

Name _____ Phone (____) _____

Address _____ City _____ State____ Zip _____

Services Desired

EVALUATION SERVICES

- ❑ Autism Diagnostic Evaluation
- ❑ Comprehensive Re-evaluation
- ❑ AAC Evaluation
- ❑ Speech/Language Evaluation
- ❑ Behavioral Evaluation
- ❑ Other:

THERAPY SERVICES

- ❑ Counseling/Psychotherapy (individual/family/group)
- ❑ Behavior Intervention Services
- ❑ Speech and Language Services
- ❑ Social Competence
- ❑ affect ☐ social skills ☐Social Cognition
- ❑ Other:

Current Concerns:

_____

_____

_____

_____

Family Information/History:

What language is primarily spoken in your home? _____

Would you like an interpreter for meetings or sessions? _____Yes ____ No

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Autism Center for Diagnosis and Treatment

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(573) 986-4985
autismcenter@semo.edu
semo.edu/autismcenter

Client History

Biological parents are:

☐ Married (or Equivalent) ☐ Separated ☐ Divorced
☐ Never Married ☐ Widowed

Client currently resides with (check one)

☐ Both biological parents ☐ Adoptive parent(s) ☐ Independent adult
☐ Biological mother ☐ Foster parent(s) ☐ Group home
☐ Biological father ☐ Grandparent(s) ☐ Other _____

If the child is in foster care, please provide name and address of agency supervising placement:

_____

People who live in the client's home

Name	Age	Relationship	Name	Age	Relationship

Other immediate family members not living in client's home

Name	Age	Relationship	Name	Age	Relationship

Siblings: Include any children who may have died and indicate if sibling has different father or mother than the client.

Name of sibling	Date of birth	Grade	Different father?	Different mother?	List any health or medical problems
			Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	
			Yes/No	Yes/No	

Annual Household Income

Number of people dependent on income: _____

☐ $0 - $20, 000 ☐ $20,000-$40,000 ☐ $40,000+

Current stressors on the family

☐ Financial ☐ Occupational ☐ Illness/Health
☐ Housing ☐ Violence ☐ Death/Loss
☐ Marital conflict ☐ Recent marriage ☐ Abuse
☐ Legal/Custody ☐ Recent birth ☐ Safety
☐ Division of Family Services (DFS) involvement: ____Current ____ Past

Are there any current legal matters within the family that are of a concern at this time (e.g., custody dispute, filed due process)? Yes ☐ No ☐ *If Yes, please describe:*

_____

Client History

Client's Ethnicity/Religion

- ☐ African American
- ☐ Asian American
- ☐ American Indian or Alaskan Native
- ☐ Hispanic
- ☐ Pacific Islander or Native Hawaiian
- ☐ Caucasian/White American

Does the client or family have any spiritual, religious, or cultural beliefs or practices that you think may affect treatment, or that we should be aware of? Yes ☐ No ☐ If Yes, please describe:

_____

Client Health History

Family Physician/Pediatrician

Name _____ Phone ( ) _____

Address _____ City _____ State ____ Zip _____

Psychiatrist/Psychiatric Nurse

Name _____ Phone ( ) _____

Address _____ City _____ State ____ Zip _____

Mother's Health During Pregnancy

Please select the trimester(s) when the following occurred:

Trimester 1 = 1-3 months; Trimester 2 = 4-6 months; Trimester 3 = 7-9 months

	Trimester			None
Infections (e.g., Flu, German Measles, Cytomegalovirus, etc)	**1**	**2**	**3**	_____
Fevers	**1**	**2**	**3**	_____
Gestational Diabetes	**1**	**2**	**3**	_____
Toxemia	**1**	**2**	**3**	_____
Seizures	**1**	**2**	**3**	_____
Hypertension	**1**	**2**	**3**	_____
Depression/other mental health conditions	**1**	**2**	**3**	_____
Emotional stress	**1**	**2**	**3**	_____
Bleeding	**1**	**2**	**3**	_____
Cramping	**1**	**2**	**3**	_____
Dehydration	**1**	**2**	**3**	_____
Blood clots in legs/lungs	**1**	**2**	**3**	_____
Smoking	**1**	**2**	**3**	_____
Alcohol consumption	**1**	**2**	**3**	_____
Recreational drug use (e.g., Marijuana, Cocaine, Crack, etc.)	**1**	**2**	**3**	_____
Other _____	**1**	**2**	**3**	_____

If Unknown Check Here _____

Client Birth History

Birth weight _____ lbs _____ oz Birth length _____ inches Head circumference ____

Client History

Was client conceived with any form of fertility assistance? If yes, please describe:

_____

_____

	Yes	No	
Premature birth			How many weeks?
Vaginal birth			
Labor induced			Why?
Prolonged labor (>23 hours)			
C-Section			Why?
Emergency delivery			Why?
Forceps used			Why?
Vacuum extraction used			Why?
Breech			
Fetal distress			High heart rate? Low heart rate?
Breathing difficulties			
Mechanical ventilation or resuscitation			Why?
Oxygen			Why?
Phototherapy for jaundice			
Blood transfusion for jaundice			
Abnormal newborn screen			Explain:
High or low blood sugar for baby			High? Low?
Other (explain):			

How many days did baby stay in the hospital following birth? _____

Early Development History and Milestones

At what age (in months) did client first do the following?

Smile responsively _____ Roll over _____ Sit unassisted _____ Pull to stand _____

Crawl _____ Walk independently _____ Become toilet trained: Day _____ Night _____

Did the client have any of the following?

Gross motor delay	**Yes/No/Unknown**	Loss of gross motor skills	**Yes/No/Unknown**
Fine motor delay	**Yes/No/Unknown**	Loss of fine motor skills	**Yes/No/Unknown**
Speech/language delay	**Yes/No/Unknown**	Loss of language abilities	**Yes/No/Unknown**

Comments about the pregnancy or birth and early milestones

_____

_____

Client History

CURRENT CONCERNS

- ❑ Communication
- ❑ Sensory Differences
- ❑ Eye Contact
- ❑ Unusual Play
- ❑ Unusual Body Movements (Hand flapping)
- ❑ Tantrums
- ❑ Aggression (Verbal/Physical)
- ❑ Self-Injury
- ❑ Sleep
- ❑ Social Skills
- ❑ Other (Briefly Describe)

_____

_____

_____

_____

Circle any history of medical problems

Allergies (Seasonal/Environmental)	Constipation	Headaches
Asthma	Feeding problems	High fever (_____degrees F)
Chronic colds	Chronic diarrhea	Head trauma/Head injury
Ear infections	Encopresis	Encephalitis
Ear tubes	Enuresis	Loss of consciousness
Hearing loss	Diabetes	Sleep Problems
Respiratory/Breathing Problems	Stomach Aches	Seizure/Epilepsy
Tonsillitis	Vomiting	Thyroid Problems

List tests, hospitalizations, surgeries, accidents, specific illnesses, and allergies and what age

- ❑ Brain scan/imaging _____
- ❑ Lead testing _____
- ❑ EEG _____
- ❑ Genetic Testing _____
- ❑ Other _____
- ❑ Describe _____
- ❑ Hospitalizations & Surgeries_____ Date _____
- ❑ _____ Date _____
- ❑ _____ Date _____

Does the client have a vision impairment? ☐ Yes ☐ No ☐ Unsure/Unknown
Nature of Impairment: _____

Does the client wear corrective lenses? ☐ Yes ☐ No

Does the client have a hearing impairment? ☐ Yes ☐ No ☐ Unsure/Unknown
Nature of Impairment: _____

Does the client wear hearing aids or have a cochlear implant? ☐ Yes ☐ No

Does the client have a history of alcohol or substance abuse (including illegal and prescription or over the counter medications)? ☐ Yes ☐ No

If yes, please provide additional information below, including any intervention that has been attempted or is needed at this time:

_____

Client History

Current medications: List all prescription and over-the-counter medications your child takes for any medical reason

Medication Name	*Dose*	*Reason Taken*	*Name of Doctor & Phone #*

Mental Health and Psychiatric Diagnostic History

Has client been diagnosed with autism in the past? ____**Yes** ____**No**

If yes, by whom and when?

	Diagnosis	Date of Diagnosis	Name of Professional
1.			
2.			
3.			

Treatment and Services History

Please list any other mental health diagnoses the client has received in the past and by whom

	Diagnosis	Date of Diagnosis	Name of Professional
1.			
2.			
3.			
4.			

Is there a history of psychiatric hospitalizations? ☐ **Yes** ☐ **No**

If yes, please give name of facility, date(s) of admission and discharge, and brief reason for admission(s)/diagnosis:

_____

_____

_____

_____

Are you receiving or have you received services from the following agencies?

Missouri Regional Center, Department of Mental Health	____**Current**	____**Past**
Easter Seals Autism Services	____**Current**	____**Past**
Vocational Rehabilitation	____**Current**	____**Past**
Special Health Care Needs, Department of Health	____**Current**	____**Past**
First Steps Ages 0-3 Program	____**Current**	____**Past**
Division of Family Services	____**Current**	____**Past**
Southeast Missouri State University Autism Center	____**Current**	____**Past**

Client History

Speech and Language Therapy:
Provider/ Agency: _____
☐ Community ☐School ☐ Past ☐Current # of hours per week: _____

Occupational/Physical Therapy:
Provider/ Agency: _____
☐ Community ☐School ☐ Past ☐Current # of hours per week: _____

Music Therapy:
Provider/ Agency: _____
☐ Community ☐School ☐ Past ☐Current # of hours per week: _____

Applied Behavior Analysis (ABA), Behavior Therapy, EIBI, or Discrete Trial:
Provider/ Agency: _____
☐ Community ☐School ☐ Past ☐Current # of hours per week: _____

Counseling/Psychotherapy:
Provider/ Agency: _____
☐ Community ☐School ☐ Past ☐Current # of hours per week: _____

Other Services:
Provider/ Agency: _____
☐ Community ☐School ☐ Past ☐Current # of hours per week: _____

Educational History

What is the name of client's current or last school? _____
What is the address? _____
What is the highest grade or degree achieved? _____
Did client ever repeat a grade? ____**Yes** ____**No** Which one? _____

Did client receive special education services from the public school system? ____**Yes** ____**No**

If yes, what is/was client's special education category? (Check all that apply)

☐ Autism
☐ Intellectual Disability
☐ Emotional (behavioral) Disturbance
☐ Speech or Language Impairment
☐ Other (please specify) _____
☐ Specific Learning Disability
☐ Young Child with a Developmental Delay
☐ Other Health Impaired

Client History

What types of school programming have you/your child attended? (Check all that apply)

- ☐ Not in a school setting
- ☐ Home school
- ☐ Birth-3 early intervention
- ☐ 3-5-year-old public preschool
- ☐ Specialized private school for children with special needs
- ☐ General education classroom
- ☐ Special education classroom
- ☐ Both general and special education classes
- ☐ Private school (regular education classes)

What kinds of grades did/does client typically earn? _____

Intellectual (IQ) Assessment

Date of last IQ assessment _____ If I.Q. has been tested, what is the result?

- ☐ Superior >130+
- ☐ High Average 116 - 130
- ☐ Average 86-115
- ☐ Borderline 71-85
- ☐ Mild Intellectual Disability 56-70
- ☐ Moderate 40-55
- ☐ Severe/Profound < 40
- ☐ Unspecified Intellectual Disability
- ☐ Unknown

FOR OLDER ADOLESCENTS AND ADULTS

Work/Vocational History

Please list current and previous employers (include vocational training sites and/or sheltered workshop sites):

_____

_____

_____

Family Work History

Mother (Biological mother of client) (Name: _____)

Race/Ethnicity

- ☐ White
- ☐ African American
- ☐ Asian
- ☐ Hispanic
- ☐ Pacific Islander
- ☐ Other

Date of birth _____

Age _____

Place of employment _____

Job title _____

Job duties _____

Level of education (check one):

- ☐ Less than seventh grade
- ☐ Partial High School
- ☐ Some college coursework
- ☐ Junior High School
- ☐ High School graduate or GED
- ☐ College degree

Highest degree attained:

☐ Associate's ☐ Bachelor's ☐ Master's ☐ Doctorate

Client History

Mother (Adoptive/Foster mother or guardian of client) (Name: _____)

Race/Ethnicity
- ☐ White
- ☐ African American
- ☐ Asian
- ☐ Hispanic
- ☐ Pacific Islander
- ☐ Other

Date of birth _____

Age _____

Place of employment _____

Job title _____

Job duties _____

Level of education for mother with whom client currently resides (check one):
- ☐ Less than seventh grade
- ☐ Partial High School
- ☐ Some college coursework
- ☐ Junior High School
- ☐ High School graduate or GED
- ☐ College degree

Highest degree attained:
- ☐ Associate's
- ☐ Bachelor's
- ☐ Master's
- ☐ Doctorate

Father (Biological father of client) (Name: _____)

Race/Ethnicity
- ☐ White
- ☐ African American
- ☐ Asian
- ☐ Hispanic
- ☐ Pacific Islander
- ☐ Other

Date of birth _____

Age _____

Place of employment _____

Job title _____

Job duties _____

Level of education (check one):
- ☐ Less than seventh grade
- ☐ Partial High School
- ☐ Some college coursework
- ☐ Junior High School
- ☐ High School graduate or GED
- ☐ College degree

Highest degree attained:
- ☐ Associate's
- ☐ Bachelor's
- ☐ Master's
- ☐ Doctorate

Father (Adoptive/Foster father or guardian of client) (Name: _____)

Race/Ethnicity
- ☐ White
- ☐ African American
- ☐ Asian
- ☐ Hispanic
- ☐ Pacific Islander
- ☐ Other

Date of birth _____

Age _____

Place of employment _____

Job title _____

Job duties _____

Level of education for father with whom client currently resides (check one):
- ☐ Less than seventh grade
- ☐ Partial High School
- ☐ Some college coursework
- ☐ Junior High School
- ☐ High School graduate or GED
- ☐ College degree

Highest degree attained:
- ☐ Associate's
- ☐ Bachelor's
- ☐ Master's
- ☐ Doctorate

Client History

Family Health History

List any biological family members who have a history of any of the conditions listed below. Indicate how affected family member is related to the client (e.g., paternal grandmother). Refer to the family member list below as a guide for how to name family members.

Maternal relatives: Maternal relatives are those related to the client on the mother's side (e.g., maternal aunt)

Paternal relatives: Paternal relatives are those related to the client on the father's side (e.g., paternal aunt)

Mother/Father/Sister/Brother/Twin (identical)/Twin (fraternal)/Half-sister/Half-brother

Condition		**Family member(s)**
Autism (including Asperger's)	**Yes/No/Unknown**	_____
Intellectual Disability	**Yes/No/Unknown**	_____
Special education	**Yes/No/Unknown**	_____
Receives SSI	**Yes/No/Unknown**	_____
Learning difficulties/disabilities	**Yes/No/Unknown**	_____
Language disorder (delayed Language, speech therapy)	**Yes/No/Unknown**	_____
Attention deficit/hyperactivity	**Yes/No/Unknown**	_____
Seizures	**Yes/No/Unknown**	_____
Depression	**Yes/No/Unknown**	_____
Anxiety	**Yes/No/Unknown**	_____
Bipolar disorder	**Yes/No/Unknown**	_____
Schizophrenia	**Yes/No/Unknown**	_____
Suicide	**Yes/No/Unknown**	_____
Alcoholism	**Yes/No/Unknown**	_____
Drug addiction	**Yes/No/Unknown**	_____
Genetic disorders	**Yes/No/Unknown**	_____
Abnormal physical features	**Yes/No/Unknown**	_____
Birth defects	**Yes/No/Unknown**	_____

Thank you for taking the time to complete this form!

_____ _____

Name of person filling out the form (Please print) **Relationship to Client**

Options for returning this form:

Mail to: Attention: Intake Department
Southeast Missouri State University
Autism Center for Diagnosis & Treatment
One University Plaza, Mail Stop 9450
Cape Girardeau, MO 63701

Fax to: *(573) 986-4994*

Treatment Consent

I hereby consent for myself/my child to participate in an evaluation and/or treatment from the Southeast Missouri State University Autism Center for Diagnosis and Treatment. I understand that the nature and goals of my child's treatment will be agreed upon by myself and my child's clinical team, and will be documented in a comprehensive report available to me or an outside referral agency upon completion of the initial evaluation or therapy. I am aware that the practice of behavioral, speech, and psychological intervention is not an exact science, and I acknowledge that there are no guarantees as to the outcome of any treatments that my child will receive.

I understand that I have the right to ask any questions I may have about the process, cost, methods, duration, and goals of the assessment or treatment; the right to discuss any concerns I may have about the assessment or my (my child's) progress in treatment; and the right to terminate the assessment or treatment if I feel I (my child) am/is not making progress.

I hereby understand that by giving my consent releases me (my child) from the claim of Southeast Missouri State University from any responsibility for injury or damage as the result of my (my child's) involvement in Autism Center activities. I understand that my signature below represents consent for participation in evaluation and/or treatment.

I, the undersigned, consent to the use and disclosure of my protected health information by Southeast Missouri State University Autism Center for Diagnosis and Treatment ("Autism Center") for the purpose of carrying out my treatment, obtaining payment for my health care or for carrying out health care operations.

I also hereby authorize the Southeast Missouri State University Autism Center to release and/or discuss the protected health information of _____(client's name) to the following individuals in the event of an emergency.

Name: _____ Relationship:_____

Address: _____ Phone: _____

_____

Name: _____ Relationship:_____

Address: _____ Phone: _____

_____

_____
Client Name

_____ _____
Signature of Client or Parent/Guardian/Personal Representative Date

_____ _____
Printed Name for Signature Above if different from client Relationship to Client

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Autism Center for
Diagnosis and Treatment

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One University Plaza, MS 9450
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573.986.4985 Phone
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autismcenter@semo.edu
semo.edu/autismcenter

Appointment Cancellation Policy

We are committed to providing all of our clients with exceptional care. We understand that sometimes you might have to miss an appointment due to emergencies and/or work/family obligations. However, when a client cancels without enough notice, it prevents another client from being seen.

For any cancellations or schedule changes for **diagnostic evaluations**, please call us at (573) 986-4985 by noon at least three business days prior to your scheduled appointment to avoid incurring a cancellation fee. To cancel a Monday appointment, please call our office by noon on Wednesday.

For any cancellations or schedule changes for **therapy services**, please call us at (573) 986-4985 by noon the day prior to your scheduled appointment to avoid incurring a cancellation fee. To cancel a Monday appointment, please call our office by noon on Friday.

These fees are NOT covered by your insurance.

If prior notification is **not** given, you will be charged $50 for diagnostic evaluation appointments and $25 for therapy service appointments (e.g., speech, behavior, or psychotherapy). This fee will be billed to you directly and will need to be paid before any other services can be scheduled.

I, _____ (client), understand and have received a copy of the Appointment Cancellation Policy, and agree to the terms.

I, _____ (parent/guardian) of _____ (child) understand and have received a copy of the Appointment Cancellation Policy, and agree to the terms.

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature Date

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STATE UNIVERSITY · 1873
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DUPLICATION OF SERVICES

Client Name _____ Date of Birth _____

- All clients have the right to:
  - Request a different provider of the same service type within the University Autism Center (UAC)
  - Obtain multiple/different services within the UAC
  - Obtain a second opinion from a service provider who provides the same or similar service
    - Example: a second opinion on diagnosis, behavioral function, goals for treatment in counseling, or a speech assessment
  - Choose between providers working in this or another agency without penalty
  - Return to the UAC for services should they leave services and then wish to return at any time without penalty
  - Continue to receive any other/additional non-duplicative services through the UAC should they choose to move to another provider in the community for a service

- All clients have a responsibility to:
  - Notify the university autism center when they begin seeing another clinician of the same service type.
    - Example: begins receiving behavior analytic services from another agency while receiving behavior analytic services from the University Autism Center.
  - Provide the UAC with notice that they will be choosing another provider so that other clients may be added to the UAC caseload.
- Because insurance companies generally do not allow for two providers of the same type to provide ongoing treatment services and;
- Because two clinicians working with the same client and who provide the same service may disagree about a particular approach to a specific treatment goal and;
- Because while collaboration is highly valued and appropriate among providers it is not feasible for providers at different agencies to engage in the multi-provider or "grand rounds" conversations necessary to ensure services are streamlined,
- We will not continue to see clients who are receiving ongoing services from a provider who delivers services that duplicate a service currently provided to them by the UAC.

Parent/Legal Guardian Signature _____ Date _____

Client Signature (if over 18 years of age) _____ Date _____

SOUTHEAST MISSOURI STATE UNIVERSITY · 1873
Autism Center for Diagnosis and Treatment

AUTISM CENTER FOR DIAGNOSIS AND TREATMENT
One University Plaza, MS 9450
Cape Girardeau, Missouri 63701

573.986.4985 Phone
573.986.4994 Fax
autismcenter@semo.edu
semo.edu/autismcenter

Media and Student Trainee Release

Client Name _____ Date of Birth _____

MEDIA RELEASE

In the interest of education, professional development, and advancement of the Southeast Missouri State University Autism Center, I, the undersigned, voluntarily authorize the Southeast Missouri State University Autism Center and its employees and agents to take photographs, videotape, and/or audio record. This media may be included in the training of students and professionals, research, dissemination of research findings (e.g., professional conferences), or promotional materials.

I have had the opportunity to ask questions about the potential uses of the media (e.g., photograph, videotape, or audio). *I understand that my refusal will not affect my ability to obtain services.*

☐ **I DO** ☐ **I DO NOT** **Initials** _____

Give permission for media to be used with my child (self) in clinical and conference settings, in addition to promotional materials. Check all that apply.

☐ photographs ☐ videotape ☐ audio ☐ other

STUDENT TRAINEE RELEASE

The Southeast Missouri State University Autism Center for Diagnosis and Treatment ("Autism Center") is a training facility. Practicum students and interns may participate in your child's evaluation and treatment. Students are closely supervised by licensed staff members and university faculty. Students are required to inform you of their student status and to tell you their faculty supervisor's name. You may request to meet the supervisor at any time. During the course of your child's care at the Autism Center, a faculty supervisor may observe a student's interactions with you and/or your child through one-way glass or via video cameras. All evaluations and therapy sessions are recorded to assist with diagnostic assessments and are for training purposes only. If you do not wish for your child to be videotaped, please discuss this with the clinician before the services begin.

I understand that my refusal will not affect my ability to obtain services.

☐ I give permission for a practicum student or intern to participate in my/my child's services.

☐ I **DO NOT** want a practicum student or intern to participate in my/my child's services

Date _____ Client or Parent/Guardian Signature _____

Printed Name _____

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MRC BILLING
Medical Billing Services

Patient Registration Form

Date	Practice & location: Southeast Missouri State University Autism Center for Diagnosis and Treatment

Patient Information

Full Name	
Date of Birth	
Sex	
SSN#	
Address	
City State Zip	
Phone	
Email	

Primary Insurance Information

Company	
Policy ID	
Group #	
Claims Address	
Claims City, ST, Zip	
Phone	
Subscriber	
DOB/SSN#	

Secondary Insurance Information

Company	
Policy ID	
Group #	
Claims Address	
Claims City, State, Zip	
Phone	
Subscriber	
DOB/SSN#	

Legal /Financially Responsible Party

Full Name	
Date of Birth	
SSN#	
Address	
City, State, Zip	
Employer Name	
Home Phone	
Email	
Relationship to Patient	

Emergency Contact

Name	
Phone	
Address	
City, State, Zip	
Relationship	
Do we have permission to contact this person concerning your medical services if the need arises?	YES ☐ NO ☐

Consent and Release

I hereby consent to treatment by, and authorize insurance benefits to be paid directly to _____.
I agree that I am responsible to pay 1) for services not covered by my insurance company, 2) co-payments and deductibles, and 3) any expenses associated with the collection of a debt owed to them by me (i.e. attorney fee, court cost or collection agency fee). I also consent to the release of pertinent medical information to my insurance carrier for the purpose of processing health care claims.

_____ (signature of responsible party)

_____ (witness)

Date:

Insurance Authorization and Billing Information

Client _____ Date of Birth _____

This document provides an explanation of the insurance and payment process, for services from the Southeast Missouri State University Autism Center for Diagnosis and Treatment ("Autism Center").

Please bring all insurance cards to every appointment. It is important to present the correct insurance card(s) for **all** insurance that you carry for your child/self, on every date of service. Failure to do so may result in receiving a billing statement from our billing department or rescheduling of your appointment.

Your insurance company may or may not authorize us to bill for your services from the Autism Center. We will call your insurance company(s) to verify benefits and obtain an authorization on your behalf for both participating and non-participating insurance companies. If we receive an authorization, we will bill your insurance company on your behalf. In some instances, your insurance company may send payment to you directly and we will then bill you for the services. You will be responsible for forwarding whatever payment you receive from your insurance company. You are responsible for all deductibles, co-insurance and copays incurred during your treatment with our facility unless you have secondary insurance for us to bill. **Copays are due at the time services are rendered**.

Authorization is not a guarantee of payment. We will process all claims to your insurance company(s); however, **any unpaid balance will be your responsibility.** We accept cash, checks, or Visa and MasterCard credit/debit cards. Failure to pay any remaining balance on your account will result in the account being turned over to a collection agency after 120 days, unless a payment plan has been arranged through our office or billing department.

_____ _____

Signature of Client or Representative Date

I hereby assign all medical, surgical, and/or third party payer benefits to which I am entitled, including private insurance, Medicare, Medicaid and/or any other health plan to: **Southeast Missouri State University** for any services provided to me by the Autism Center. I authorize the Autism Center to release any medical information to such private insurance, the Centers for Medicare & Medicaid Services and/or any other health plan to the extent such information is needed to determine benefits or benefits payable for related services. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. If the above services are being provided to a minor, the personal representative below agrees that he/she is financially responsible for all charges whether or not paid by said insurance.

_____ _____

Signature of Client or Representative Date

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Consent for Telehealth Consultation and Electronic Communication

The Southeast Missouri State University Autism Center for Diagnosis and Treatment now provides psychological, speech and language, and behavioral services via interactive video communications and/or by the electronic transmission of information in order to better serve the needs of the people in the community. This may assist in the evaluation, diagnosis, management and treatment of various psychopathologies. This process is referred to as "telehealth" or "teleconsultation". This means that you may be evaluated and treated by a licensed professional from a distant location. It is important that you understand and agree to the following statements.

1. I understand that my provider wishes for me to engage in a telehealth consultation.
2. My provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as direct patient/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue telehealth consults/visits if it is felt that the videoconferencing connections are not adequate for the situation. In further understand that email is not a secure form of communication.
4. The consulting licensed professional will be at a different location from me. A supervisee (e.g., other licensed professional, or practicum student) may or may not be present with me in the room to assist in the consultation.
5. The other licensed professional or practicum student may transmit or share electronically details of my history/background, evaluations, requested data, photographs, or other images with the consulting licensed professional at a different location.
6. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the other licensed profession or practicum student, and via video, the consultant. I will give my verbal permission prior to the entry of the additional personnel.
7. The licensed professional for whom the on-site evaluation and/or treatment is performed will keep a record of the consultation in my medical records.
8. I voluntarily consent to services provided by the licensed professional or a designee, which may include diagnostic evaluations, assessment and treatment of speech and language, assessment and treatment of appropriate and inappropriate behavior, and assessment and treatment of various psychopathology.
9. I understand that I may be released before all of the problems are known or treated and it is my responsibility to make arrangements for follow-up care.
10. I understand that I have the option to refuse telehealth service at any time without affecting the right to future care or treatment and without risk of losing benefits.
11. I understand that appointments will be confirmed via email.
12. I consent to the use of email and request that communication of protected health information related to _____, be sent to my preferred email address. My preferred email address is: _____.

I (or as guardian for _____, a minor/dependent) hereby authorize Southeast Missouri State University Autism Center for Diagnosis and Treatment to disclose protected health information, including complete health record and/or records relating to mental health care to the entity(s) that may be providing telehealth consultation as part of this Consent for Telehealth Consultation.

Client Printed Name _____ Date of Birth _____

Client/Representative Signature _____ Date _____

Representative Printed Name_____ Relationship to Patient _____

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Authorization for Use or Disclosure of Protected Health Information

NAME OF CLIENT:_____ DOB:____/____/_____

I hereby authorize:

Southeast Missouri State University
Autism Center for Diagnosis and Treatment
One University Plaza, MS 9450
Cape Girardeau, MO 63701

☐ TO DISCLOSE TO
☐ TO OBTAIN FROM

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

INFORMATION TO BE DISCLOSED: (Please check all that apply)

☐ IEP/School Reports/Testing ☐ Testing Reports ☐ Intake/Discharge Summary
☐ Speech/Language Evaluations/Assessments ☐ Psychological/Evaluation Reports ☐ Diagnostic Summary
☐ IQ/Cognitive Assessments ☐ Other:_____ ☐ Verbal Consultation
☐ Reports from University Autism Center:_____

Dates of service: From:____/____/_____ To:____/____/_____ OR ☐ All

PURPOSE OF THIS DISCLOSURE:_____
The information selected above is released for the stated purpose only and any other use is prohibited.

PLEASE READ CAREFULLY
I understand that:
___I may revoke this authorization at any time. I understand that my revocation must be in writing (on this form or by letter). I further understand that actions already taken on this authorization, prior to revocation, will not be affected.
___The protected health information used or disclosed pursuant to this authorization may be disclosed to someone who is not required to comply with federal and/or state law/regulations and that such information may be re-disclosed and would no longer be protected
___ My medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my behavioral health information, including information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, alcohol/drug abuse, and/or psychiatric/neural/behavioral health treatment.
___ I have the right to receive a copy of this authorization.
___ No treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) may be conditioned on whether I sign the authorization unless:
- The treatment being provided is research-related and the medical information is to be used for that research; or
- The health care that the above-referenced medical provider is providing is being provided solely for the purpose of providing medical information to a third party.

___Unless otherwise revoked in writing, this authorization will expire one year from the date the authorization is signed.
I certify that I have received a copy of the authorization and have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____
Signature of Patient or Personal Representative Date Authorization is Signed

_____ _____
Printed Name of Patient or Personal Representative Relationship to Client

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertain or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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autismcenter@semo.edu
semo.edu/autismcenter

Authorization for Use or Disclosure of Protected Health Information

NAME OF CLIENT:_____ DOB:____/____/_____
I hereby authorize:

Southeast Missouri State University
Autism Center for Diagnosis and Treatment
One University Plaza, MS 9450
Cape Girardeau, MO 63701

☐ TO DISCLOSE TO
☐ TO OBTAIN FROM

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

INFORMATION TO BE DISCLOSED: (Please check all that apply)

☐ IEP/School Reports/Testing ☐ Testing Reports ☐ Intake/Discharge Summary
☐ Speech/Language Evaluations/Assessments ☐ Psychological/Evaluation Reports ☐ Diagnostic Summary
☐ IQ/Cognitive Assessments ☐ Other:_____ ☐ Verbal Consultation
☐ Reports from University Autism Center:_____

Dates of service: From:____/____/_____ To:____/____/_____ OR ☐ All

PURPOSE OF THIS DISCLOSURE:_____
The information selected above is released for the stated purpose only and any other use is prohibited.

PLEASE READ CAREFULLY
I understand that:
___I may revoke this authorization at any time. I understand that my revocation must be in writing (on this form or by letter). I further understand that actions already taken on this authorization, prior to revocation, will not be affected.
___The protected health information used or disclosed pursuant to this authorization may be disclosed to someone who is not required to comply with federal and/or state law/regulations and that such information may be re-disclosed and would no longer be protected
___ My medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my behavioral health information, including information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, alcohol/drug abuse, and/or psychiatric/neural/behavioral health treatment.
___ I have the right to receive a copy of this authorization.
___ No treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) may be conditioned on whether I sign the authorization unless:
- The treatment being provided is research-related and the medical information is to be used for that research; or
- The health care that the above-referenced medical provider is providing is being provided solely for the purpose of providing medical information to a third party.

___Unless otherwise revoked in writing, this authorization will expire one year from the date the authorization is signed.
I certify that I have received a copy of the authorization and have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____
Signature of Patient or Personal Representative Date Authorization is Signed

_____ _____
Printed Name of Patient or Personal Representative Relationship to Client

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SOUTHEAST MISSOURI
STATE UNIVERSITY · 1873

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let us know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, the University Autism Center may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, we will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, staff, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. *Initial each to indicate that you understand and agree to these actions*:

- You will only keep your in-person appointment if you are symptom free. ___
- Permit us to take your temperature before beginning each appointment. If your temperature is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, you will not be charged our normal cancellation fee. __
- You will call the office upon your arrival in the Center's parking lot to notify your practitioner you are ready for your appointment.
- You will wait in your car or outside [or in a designated safer waiting area] until your practitioner picks you up for your appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up throughout the building.___

- You will wear a mask in all areas of the office (staff will too). ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands). ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You agree that while working with your child, we will be permitted to wash and sanitize your child's hands frequently during therapy/assessment sessions. ___
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let us know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let us know. ___
- If a resident of your home tests positive for the infection, you will immediately let us know and we will then begin/resume treatment via telehealth.___

The above precautions may change if additional local, state or federal orders or guidelines are published. You will be notified of any additional changes.

Our Commitment to Minimize Exposure

The University Autism Center has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on the university website and in the office. Please let us know if you have questions about these efforts.

If You or Your Practitioner Are Sick

You understand that the Center is committed to keeping you, our staff, and all of our families safe from the spread of this virus. If you show up for an appointment and office staff believe that you have a fever or other symptoms, or believe you have been exposed, we will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate. If office staff test positive for the coronavirus, we will notify you so that you can take appropriate precautions. Further, our offices will be closed to in-person sessions for a period of 14 days.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, we may be required to notify local health authorities that you have been in the office. If we have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent and treatment plan we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____	_____
Client	Date of Birth
_____	_____
Parent/Gaurdian	Date