



Alta Vista Center  
for Autism

The Art and Science of Effective Intervention



# Intake Packet

Revised  
10 July 2009

## CLIENT REGISTRATION FORM

**Date** \_\_\_\_\_

Client Full Legal Name (Last, First, MI): _____			
Street Address: _____			
City: _____	State: _____	Zip: _____	
Date of Birth: _____	Sex: _____	Social Security Number: _____ - _____ - _____	
Diagnosis: _____			
Other Conditions: _____			

Ethnicity of Child: check all that apply				
African- American _____	Asian- Pacific _____	Caucasian _____	Hispanic _____	Other _____
Language (s) spoken in the home: _____				

Mother / Legal Guardian: _____		
Relationship: (please check)		
Biological _____	Adoptive _____	Foster _____
Address: _____		
Home Phone ( ) _____	Work Phone: ( ) _____	Cell: ( ) _____
Email: _____		
Occupation: _____		Title: _____
Highest level of education (please circle)		
High School 9, 10, 11, 12	College 1, 2, 3, 4	Graduate School
Employer: _____		
Employer Address: _____		
City: _____	State: _____	Zip: _____

Father/ Legal Guardian: \_\_\_\_\_  
Relationship: (please check)  
Biological \_\_\_\_\_ Adoptive \_\_\_\_\_ Step \_\_\_\_\_ Foster \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_  
Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Title: \_\_\_\_\_  
Highest level of education (please circle)  
High School      College      Graduate School  
9, 10, 11, 12      1, 2, 3, 4  
Employer: \_\_\_\_\_  
Employer Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parents' Marital Status: Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_  
Child lives with (*check all that apply*) Father \_\_\_\_\_ Mother \_\_\_\_\_ other (specify) \_\_\_\_\_

CLIENT'S SIBLINGS

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

CLIENT'S PRIMARY CARE PHYSICIAN

Name: \_\_\_\_\_ Clinic/Company practice: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
Email: \_\_\_\_\_

THERAPY INFORMATION

To better coordinate services please list client's current therapies, or other treatment professionals:

Date started: \_\_\_\_\_

Treatment: \_\_\_\_\_

Service provider: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Date started: \_\_\_\_\_

Treatment: \_\_\_\_\_

Service provider: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Date started: \_\_\_\_\_

Treatment: \_\_\_\_\_

Service provider: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Date started: \_\_\_\_\_

Treatment: \_\_\_\_\_

Service provider: \_\_\_\_\_

Contact Information: \_\_\_\_\_

SCHOOL INFORMATION

Current Grade Level: \_\_\_\_\_

Facility: \_\_\_\_\_ Date Started: \_\_\_\_\_

Contact Information: \_\_\_\_\_

## CLIENT QUESTIONNAIRE

**Client Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### **PART I – CONCERNS & STRENGTHS**

What specific concerns do you have about your child?

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When did you first develop these concerns?

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Whom have you seen previously about your concerns and what were you told about your child?

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What are your child's interests and strengths? What does he/she like to do?

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What are your child's likes and dislikes?

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What questions would you like answered during the evaluation?

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What agency or individual referred you here for evaluation?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**PART II – FAMILY HISTORY**

Is there any history of the following on either side of child’s biologic parents’ families? If yes, indicate with an “X” on FATHER’S or MOTHER’S side and explain who (grandmother, etc.) in last section.

#	DESCRIPTION	NO	YES	FATHER’S	MOTHER’S	WHO?
1	Psychological/Emotional					
2	Mental Retardation					
3	Learning Disabilities					
4	Birth Defects					
5	Seizures/Convulsions					
6	Tuberculosis					
7	Neurological Disease					
8	Diabetes					
9	Cancer					
10	Allergies/Asthma					
11	Gland Disorder/Thyroid					
12	Hearing Impairments					
13	Vision Impairments					
14	Hyperactivity					
15	Miscarriages					
16	Slow Development					
17	Autism					
18	Fragile X					
19	Speech Problems					
20	Other ---					

**Comments:** Explain conditions present on either side of family. (i.e. Specific conditions, etc)

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**PART III – PREGNANCY & BIRTH HISTORY**

Please list all pregnancies and miscarriages of child’s biological mother, in chronological order.

Birth Date	Birth Weight	Health or Developmental Description

Please describe anything unusual or exceptional about the pregnancy and/or birth of the child being evaluated:

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Was baby born early, late or on time? (circle) # of weeks? \_\_\_\_\_

Was baby born by normal vertex (head down), breech or c-section?

Baby’s birth weight \_\_\_\_\_ and length \_\_\_\_\_.

Apgar score? \_\_\_\_\_

Are biologic parents related by blood? Yes No How?

*Please check the following if present during pregnancy or birth:*

Excessive bleeding	Fever	Rash
Prescription Drugs	Toxemia	Poor weight gain
Illicit/street drugs	Cigarettes	Narcotics
Alcohol	Supplemental oxygen	Illnesses

*Please check the following if present during newborn period:*

Jaundice	Feeding difficulties	Suspicion of infection
Poor temperature control	Poor activity	Other?

*Nutritional History:*

Breast fed?	Yes	No	For how long?
Formula fed?	Yes	No	Name of formula?
When were foods added?	When weaned to cup?	Weight at 1 year?	

Present diet concerns?
Do you have concerns about your child's current eating habits?

**PART IV – DEVELOPMENTAL HISTORY**

DEVELOPMENTAL MILESTONES: Write down the age when your child first did each of the following. Write "no" if your child has not yet done it. If you do not remember, please leave it blank.

Smiled		Held head erect		Separated easily from mother	
Imitated sounds		Rolled over		Ate unaided with spoon	
Said "mama" or "dada"		Sat alone		Knew Colors	
Said other single words		Crawled		Started counting	
Followed simple directions		Walked alone		Recited total alphabet	
Said 2-3 word phrases		Rode tricycle		Read Words	

In general, did you feel your child developed quickly, typically or slowly?

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TEMPERAMENT: Please comment on the following behaviors for you child as an infant and as a toddler:

How active is your child?
How well does your child deal with transition and change?
How well does your child respond to new places, people and things?
What is your child's basic mood? Happy? Sad? Angry? Quiet? Other, please explain?
Is your child predicable in patterns of sleep, appetite, etc.?

**PART V – CLIENT’S MEDICAL HISTORY**

Please indicate if the following are relevant currently or in the past. A brief explanation is helpful.

#	DESCRIPTION	NO	YES	EXPLANATION
1	Abdominal pain/bowel issues			
2	Allergies			
3	Anemia			
4	Birth Defects			
5	Concussion/head injury			
6	Dental problems			
7	Drooling			
8	Ear infections			
9	Eating issues/gags/chokes			
10	Headaches			
11	Hearing loss			
12	Heart condition			
13	Blood disorders			
14	Hormone problems			
15	Ingestion poisons			
16	Joint or bone problems			
17	Lung or breathing problems			
18	Muscular problems			
19	Seizures or convulsions			
20	Significant accidents			
21	Skin disease			
22	Tics or repetitive movements			
23	Urinary problems/infections			
24	Visual/eye problems			
25	Other medical concerns			

Hospitalizations: List any hospitalizations, operations of child:

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Medications: List medication (s) child currently takes:

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Current weight: \_\_\_\_\_ Current height: \_\_\_\_\_

Are your child's immunizations up to date? Yes \_\_\_\_\_ No \_\_\_\_\_

#	DESCRIPTION	NO	YES	EXPLANATION
1	Difficulty toilet training			
2	Temper tantrums			
3	Breath holding			
4	Destructiveness			
5	Disobedience			
6	Sleep problems			
7	Bedwetting			
8	Masturbation			
9	Nail biting			
10	Thumb sucking			
11	Self- injurious behavior (e.g. head banging)			
12	Unusual Fear			
13	Poor concentration			
14	Distractibility			
15	Aggression			
16	Eating problems			
17	Cruelty to animals			
18	Mood swings			
19	Hair pulling			

Any other behavior issues you would like to mention or explain:

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Does your child:

#	DESCRIPTION	NO	YES	EXPLANATION
1	Get along with other children			
2	Become easily upset or frustrated			
3	Become angry or destructive easily			
4	Become overactive			
5	Prefer to be alone			
6	Misbehave frequently			
7	Have difficulty sitting still			
8	Have any problem with awkwardness or clumsiness			
9	Listen well			
10	Follow spoken directions			

How do you discipline your child? Please give an example.

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**PART VI – EDUCATIONAL PROFILE**

Please indicate schools attended in chronological order.

School Name and Level	Date Attended

Has your child ever received special education services? Please explain.

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Describe any current school programs.

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Has your child ever received any developmental evaluation or testing in the past?

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## CLIENT'S RIGHTS FORM FOR EVALUATIONS

Client's Name: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

During the treatment or evaluation process, you and your child will be working with a team of professionals from several disciplines. We will work with you to learn about your child and family. The Alta Vista Center does provide training to students in psychology, education and other service fields. You may receive some services from a trainee supervised by one of the staff members.

There is a state regulatory agency which governs practice by both licensed and unlicensed psychologists in Colorado. If you have any question or complaints about the or psychology services you receive, you have a right to contact the Mental Health Occupations Grievance Board, 1525 Sherman Street, Room 128, Denver, Colorado 80203, phone (303) 866-3248. You are entitled to information about the methods and techniques used in evaluation and treatment and the fee structure. Also, you may always seek a second opinion or end the process at anytime. In a professional relationship, sexual intimacy is not appropriate and should always be reported to the Grievance Board.

## CONSENT FOR TREATMENT

\_\_\_\_\_ (name of child), a minor, may have a condition requiring evaluation and/or treatment. As a parent/guardian I apply for and consent to evaluation such as routine diagnostic procedures. The staff of The Alta Vista Center will also collect background, environmental and socioeconomic information. Information I provide is confidential as is the medical record. Only persons authorized by me can have the records, except as required by law.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

**CONSENT TO REQUEST/RELEASE MEDICAL INFORMATION**

To: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_ Attn: \_\_\_\_\_

I hereby authorize The Alta Vista Center to \_\_\_\_\_ obtain or \_\_\_\_\_ release any medical, psychological, school, or social records or information concerning the below-named individual. This information will be used for services I have requested.

Client Name: \_\_\_\_\_

\_\_\_\_\_  
Date of Birth Social Security Number

**AUTHORIZATION**

I hereby certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has been taken to comply with it.

I understand that this consent will expire \_\_\_\_\_

A copy of this authorization is to be considered as valid as the original.

I release the Alta Vista Center for Autism from all liability pertaining to disclosure of information concerning the records of the above-named individual.

\_\_\_\_\_  
Signature of individual served

\_\_\_\_\_  
Parent/Legal guardian (Representative of individual)

\_\_\_\_\_  
Date of signatures

Please send information to: The Alta Vista Center for Autism  
2695 S. Jersey Street  
Denver, CO 80222  
(303) 759-1194 fax Attn: \_\_\_\_\_

## **E-MAIL CONSENT TO COMMUNICATE WITH HEALTH CARE PROVIDERS**

**Client/Guardian name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I request to communicate with my health care provider (s) using electronic mail. I realize that the following risks and benefits apply.

### **RISKS:**

#### **The confidentiality of e-mail communication cannot be assured.**

- E-mail communication may be viewed by third parties.
- E-mail is sent across an open computer network and is generally unencrypted. It is thus accessible to prying eyes similar to a postcard.
- E-mail sent using an employer's e-mail system could legally be read by the employer.
- The biggest threat to the confidentiality of e-mail is not hackers intercepting messages, but messages that are mis-addresses, mistakenly forwarded to others, or are read using shared e-mail accounts or on computer screens when one forgets to log-off.

### **BENEFITS:**

- Use of e-mail may eliminate "telephone tag" between client and health care provider.
- Non-urgent messages and questions may be communicated with less interruption than by phone.
- E-mail allows a written record of communication which can be a useful reference.

### **GUIDELINES FOR E-MAIL COMMUNICATION:**

#### **Appropriate uses of e-mail for medical communication include:**

- Address and telephone numbers of referring facilities;
- Test results with interpretation and recommendation;
- Medication instructions and refill information;
- Before-admission and after-discharge instructions;
- Client education;
- Questions and answers about issues discussed during a previous visit;
- Questions and answers about new symptoms by an established client;
- Verification of future appointment dates/times;
- Other messages of a similar nature to the topics above.

#### **E-mail SHOULD NOT be used to communicate:**

- Emergencies and other time-sensitive issues
- Requests for medical advice before the client-physician relationship has been established'
- Sensitive information, defined as any information that the client would not want anyone other than the health care provider to have.

**Additional Recommendation:**

- Put client name in the subject line;
- Keep copies of e-mail you receive from your health care provider;
- Your health care provider will be saving and printing e-mail messages to be filed in your medical record. Your health care provider may share your messages with his/her office staff or consultants if necessary. This consent form applies to all health care providers who are providing care to you at this clinic. E-mail correspondence may be terminated by either the client or health care provider at any time.

I, \_\_\_\_\_ (name of client/guardian) understand the risks, benefits, and appropriate uses of e-mail communication with my health care providers. I recognize that the confidentiality of medical information discussed in e-mail communication can not be assured and I accept that risk. I understand that it is my responsibility to identify for my health care providers any medical information that I expressly do not want communicated via e-mail. I agree to follow the guidelines listed above. I agree to follow the guidelines listed above regarding the appropriate and inappropriate uses of e-mail communication with my health care providers.

I have reviewed the information above and wish to proceed.

\_\_\_\_\_  
Client/Guardian E-mail Address

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
Date



## NOTICE OF PRIVACY PRACTICES

Effective September 1, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** This notice is posted pursuant to State and Federal laws that require The Alta Vista Center for Autism (AVCA) to protect the privacy of client health information, including medical records, and to provide you with notice of AVCA's legal duties and privacy practices with respect to this information. AVCA clients are entitled to receive a paper copy of this Privacy Notice by the first date of service, or as soon as reasonably practical in an emergency treatment situation.

### Understanding Health Records and Information

Each time a client receives therapy or a parent consults with personnel at AVCA regarding his or her child a record of that visit is made. Typically this record contains the client's name and other information that may identify you, diagnoses, treatment, plan for future health care, and financial information.

### Uses and Disclosures of Protected Health Information

AVCA is permitted to use and disclose protected health information *without* your written Authorization for the purpose of treatment, payment, or health care operations, as follows:

**Treatment.** Treatment refers to the provision, coordination, or management of health care and related services by one or more health care providers. For example, your child's therapist may use your information to plan your child's course of treatment or to consult with other AVCA staff or professional colleagues. Disclosure made by you to your mental health therapist remain privileged and will not be released without your written consent as provided for by Colorado's Privilege Communication Law.

**Payment.** Payment refers to the activities undertaken by AVCA to obtain reimbursement for the provision of (mental) health care. AVCA will use some of your information (such as your name, diagnosis, service dates, description of service) to develop a computerized billing database which includes information based on time sheets submitted by your child's clinician, accounts receivable, statements and other billing records.

**Health Care Operations.** Health Care Operations refer to activities undertaken by your provider or AVCA which are related to the management and administration of AVCA services. For example, your therapist may use or disclose your health information in internal quality assurance activities, including chart audits and case reviews.

**Other Situations.** In addition, AVCA is permitted or may be required to use or disclose information without your written authorization in the following circumstances:

1. AVCA staff may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. As required by law this includes, but is not limited to, reporting child abuse or neglect; when AVCA is court ordered to release information; when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
3. If a client is involved in a crime on the premises, or observed by AVCA staff to commit a crime, it will be reported to law enforcement.
4. AVCA may be required to disclose protected health information to health authorities and health oversight agencies as authorized by law.
5. Certain non-clinical services necessary to AVCA's operation are outsourced or provided by other agencies such as accounting, collections, computer technical assistance, and legal advice, and other "business associates." Protected health information may be released to these business associates as needed so they can perform their contracted responsibilities. Business associates are required to enter in an agreement maintaining the privacy of any client information released to them.

6. Ordinarily, protected health information is not to be released to family members without the consent of the client or legal guardian. However, in situations where family members are present during an encounter with a client, and the client does not object, information may be disclosed during the encounter. Protected Health information will not be disclosed if the client objects.
7. Information on clients who are court ordered to treatment can be shared with other treatment providers, law enforcement officials and third party payers as necessary or as required by rule.
8. In life-threatening emergencies AVCA providers may disclose the information necessary to avoid death or serious injury.
9. AVCA providers may use or disclose protected health information for research purposes as long as Federal Privacy Rules are followed, including appropriate de-identification procedures.

Any other use or disclosure of protected health information will require your written authorization, e.g., for marketing purposes. You may revoke an Authorization or Release of Information at any time, provided that the revocation is in writing, except to the extent that AVCA has taken action in reliance thereon.

### **Your Rights as a Client**

You have the *right to request restrictions on certain uses and disclosures of protected health information* for treatment, payment, or health care operations. AVCA is not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. Any other limitations pertinent to your request will be provided to you at the time of your request.

You have the *right to request to receive confidential communications of protected health information* from AVCA by alternative means or alternative locations. For example, you may request that we contact you at home, rather than at work. Although there may be limitations to the granting of such requests, AVCA will do its best to accommodate reasonable requests.

You have the *right to inspect and copy protected health information* contained in your designated record set, which includes medical and billing records used by AVCA to make decisions about your care (with the exception of psychotherapy notes and test data). You will be charged for photocopying of these records. There are other limitations to this right, which will be made known to you at the time of your request.

You have the *right to submit a written request that AVCA amend protected health information* or any record in the designated record set, if you believe it is incorrect or incomplete. AVCA may decline to make such an amendment if it determines that the record was not created by AVCA or is, in fact, accurate and complete.

You have the *right to receive an accounting of disclosures of your protected health information* made by AVCA in the six years prior to the date of your request, except for those pertaining to treatment, payment or health care operations. Such an accounting may also not include disclosures made to you, disclosures made in response to your signed Authorization, or disclosures made prior to the effective date of this Notice.

You have the *right to revoke authorization to use or disclose health information* except to the extent that action has already been taken.

To exercise any of these rights, please contact the AVCA Privacy Officer.

### **Other Information**

AVCA is required by law to abide by the terms of this notice, or any subsequent amended Notice. AVCA reserves the right to change the terms of this notice and to make the new Notice provisions effective for all protected health information that it maintains. If this notice is revised, it will be posted and a paper copy available on request.

If you feel your privacy rights have been violated you may file a complaint with AVCA's Executive Director and/or to the Secretary of Health and Human Services, c/o Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Building, Washington D.C., 20201. AVCA may not penalize you for filing such a complaint.

## OUTPATIENT TREATMENT/EVALUATION AGREEMENT

1. **Consent for Treatment.** I now voluntarily consent to outpatient care and treatment or evaluation performed by clinicians at the Alta Vista Center. This consent for treatment is valid for all outpatient care that is provided for at least one (1) year from the date I sign this agreement. I understand that I can revoke this consent for treatment at any time in writing to the Alta Vista Center.
2. **Payment Agreement.** Whether I sign as the client or as the guardian, conservator or agent of the client, I assume full responsibility for and agree to pay all costs, charges, and expenses for The Alta Vista Center for Autism. Each bill for all Alta Vista Center charges shall be due and payable by the client, parent, his/her agent, guardian, conservator or third party responsible for payment at time of service or on the date stated on the bill. I now agree to pay all costs and fees, including attorney fees, in the event Alta Vista Center for Autism brings any action because of any failure by someone or me on my behalf to pay the Alta Vista Center for Autism bills in full.
3. **Preauthorization Requirements.** I understand that it is my responsibility to obtain all preauthorizations and to comply with all requirements of any insurance plan that I am relying on for coverage of Alta Vista Center of Autism charges.
4. **Authorization for Release of Information.** I authorize The Alta Vista Center for Autism to release necessary confidential medical information contained in my medical record to any financial sponsor, insurance company, or managed care company of the client's as may be required for payment to be made on the client's account for the service rendered. I understand this authorization for release of information can be revoked in writing, this consent will terminate one (1) year after signature.
5. **Cancellation.** Should I be unable to attend my scheduled appointment, I will notify by phone my clinician (leaving a message as necessary) or call the clinic phone number as noted in the Client Information materials given to me. I understand that I will be billed a regular therapy fee if the clinician/clinic has not been notified at least twenty-four (24) hours prior to my scheduled visit. Please note that insurance will not reimburse for missed appointments.

I HAVE READ THIS FORM, I UNDERSTAND WHAT IT SAYS, IT HAS BEEN FULLY EXPLAINED TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED. BY SIGING THIS FORM I UNDERSTAND AND AGREE TO WHAT IT SAYS.

\_\_\_\_\_  
Client or parent/guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Financially responsible party (if not client or parent)

# The Alta Vista Center for Autism

*The Art and Science of Intervention*

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF ALTA VISTA CENTER PRIVACY PRACTICES

**\*\*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT\*\***

I, \_\_\_\_\_ have received a copy of The Alta Vista  
Center

Print full name

for Autism's Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Name of Dependent/s

\_\_\_\_\_  
Date

### **\*FOR OFFICE USE ONLY\***

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,  
but acknowledgement could not be obtained because:

- Guardian not present for appointment of minor patient; forms sent with patient
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Individual refused to sign
- Other (please specify)

# The Alta Vista Center for Autism

## *The Art and Science of Effective Intervention*

### BILLING POLICIES

Payment for on-site consultations, therapies, and clinical services are due at time of service.

Cancellations--The Alta Vista Center for Autism requires at least 24 hours notice to cancel a scheduled therapy, evaluation or consultation session. Clients will be charged the full amount of the therapy session for cancellations made within 24 hours, except in case of illness or emergencies. Due to number of clients who may be on waiting lists for therapy, multiple cancellations in a semester may result in a loss of your assigned appointment time.

Non-sufficient funds- \$40.00 fee on all checks returned for non-sufficient funds. Upon receiving two non-sufficient fund checks, we will no longer accept personal checks. Payments must be in the form of a money order, cashier's check or cash. NSF checks must be reimbursed within 24 hours upon notification from the Alta Vista Center for Autism (fees included).

Late payment fee- all payments more than ten days past due will be subject to a late fee.

Delinquent payment penalty- unpaid or late payments may result in service termination from the Alta Vista Center for Autism. Student records will not be released until all accounts have been satisfied. If the payment has not been received after 60 calendar days, it will be submitted to a collection agency for collection.

Insurance billing – The Alta Vista Center does not bill insurance companies directly; however, you will receive a statement reflecting your payment. We cannot advocate insurance requests on an individual basis. This service is not included in program or service fees and we do not have designated personnel to manage these efforts. .

**PAYMENT METHODS:** The Alta Vista Center for Autism accepts payments of personal check, money order, credit card, and electronic bank payment.

**\*I have read the above policies and agree to them. I understand that I am responsible for timely payment of all fees, and in the event of a third party payer, I am ultimately responsible for payment should the other party fail to do so.**

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Day Phone

\_\_\_\_\_  
Night Phone

\_\_\_\_\_  
Email Address