Achievement Partners
SKILLS CENTER

Cancellation & Missed Appointment Policy

We are committed to the well-being of your child and to providing him/her with consistent services. Adherence to the recommended number of treatments is a vital component of progress for all children. We expect attendance of all scheduled appointments. In case of illness, inclement weather, or the need to reschedule an appointment, we require a 24-hour notice. Please contact our office to reschedule any missed appointments. **Missed appointments without appropriate notice will result in a $25.00 fee.**

In instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care. We will inform your physician and care manager of the fact that your service has been discontinued due to non-compliance with the recommended treatment plan.

We greatly appreciate working with your child. We are committed to working with you and your child to support all your efforts to optimize your child's progress.

I have read and understand this policy:

Signature of parent/guardian:_____ Date:_____

Name of parent/guardian: _____
(please print)

Name of patient:_____
(please print)

1372 Harrisburg Pike Lancaster, PA 17601 (717) 723-9765
www.AchievementPartners.com admin@achievementpartners.com

Consent For Care & Treatment

I, the undersigned, do hereby agree and give consent for Achievement Partners to furnish care and treatment to (patient)_____that is considered necessary and proper in treating his/her skill deficits.

Notice of Privacy Practices

As per HIPPA guidelines, I acknowledge that I have read and understand the notice of Privacy Practices for Achievement Partners and may be furnished with a copy upon my request.

Benefit Assignment

I hereby assign medical benefits to which I am entitled, including Medical Assistance, private insurance, and third-party payors to Achievement Partners. A photocopy of this assignment is to be considered as valid as the original.

Financial Policy Statement

If any payment is made directly to me for services billed by Achievement Partners, I recognize an obligation to promptly remit that amount along with any explanations of payment to Achievement Partners. I understand that if I fail to make any of the payments for which I am responsible in a timely manner I will be responsible for all costs of collecting monies owed including original charges, interest, collection agency fees and attorney fees.

Billing and Benefits

It is the patient's responsibility to maintain all prescriptions, referrals and authorizations as required by your insurance company. We will bill your insurance carrier as a courtesy to you. Generally, your insurance policy will cover some portion of the services provided. Please note: There is no guarantee of payment. Should your insurance carrier deny payment, the total uncovered balance will be transferred to personal pay and will be your responsibility. You are also responsible for any deductible, co-pay, co-insurance, or ineligible charges.

I have read the above information and understand my responsibilities.

_____

Parent/Guardian Signature Date

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Insurance Information

Date:_____

Parent/Guardian or Responsible Party

Last Name_____ First Name_____ M.I._____

Address_____

Social Security #_____ D.O.B_____

Phone_____ Email_____

Employer_____ Relationship to Client_____

Primary Insurance

Insurance Co. Name_____

ID #_____ Group #_____

Insurance Co. Address_____

Subscriber Name _____ D.O.B._____

SS#_____ Relationship to Patient_____

Secondary Insurance

Insurance Co. Name_____

ID #_____ Group #_____

Insurance Co. Address_____

Subscriber Name_____ D.O.B._____

SS#_____ Relationship to Patient_____

Achievement Partners
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Date:_____ Child's name:_____ Sex: ☐M ☐F

Nickname:_____ Birth Date:_____ Age:_____

Primary Diagnosis: _____ Secondary Diagnosis:_____

Diagnosed by: _____ Date of Primary Diagnosis:_____

Family Information

Client lives with: _____

Caregivers Marital Status: _____ Married _____Separated _____Divorced

Parent/Guardian 1

Name: _____Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Employed by: _____Occupation: _____

Employer Address: _____Employer Phone: _____

Parent/Guardian 2

Name: _____Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Employed by: _____Occupation: _____

Employer Address: _____Employer Phone: _____

Siblings

Name _____ DOB: _____ Grade: _____

Name _____ DOB: _____ Grade: _____

Name _____ DOB: _____ Grade: _____

Medical Information

Hospital Preference: _____

Urgent Care Preference:_____

Client's Primary Doctor: _____ Phone Number: _____

Practice Name:_____Town: _____

Medical Information cont.

Allergies: _____

List any medical restrictions to client's activities: _____

List any special dietary needs: _____

List current medications and over-the-counter supplements

Medication Name	Dosage	Frequency	Prescriber Name

Additional Service Providers

Service	Agency/Practice Name	Provider Name	Frequency
Special Education Services (list):			
Personal Care Assistant (PCA)			
Psychiatrist			
Physical Therapy			
Speech Therapy			
Occupational Therapy			
Outpatient Therapy			
Family Therapy			
Family Based Services			
BHDS Case Management			
Before/After school care			
STAP Camp			
Other:			

Needs (check all that apply)

- ☐ Interaction with peers
- ☐ Independent play/leisure activities
- ☐ Working in a group
- ☐ Classroom readiness
- ☐ Nonverbal communication
- ☐ Managing emotions
- ☐ Self-regulation
- ☐ Conversation
- ☐ Sportsmanship
- ☐ Confidence/Self-esteem
- ☐ Self-advocacy
- ☐ Perspective taking
- ☐ Approaching others
- ☐ Repetitive behaviors
- ☐ Other: _____

_____

Please provide copies of the following documentation as applicable:

- ☐ IEP
- ☐ 504 Plan
- ☐ Psychological evaluation (school/private)
- ☐ Previous ABA assessments or Behavior plans
- ☐ Custody Agreement/Guardianship
- ☐ Insurance card(s)
- ☐ Driver's license/ID card of primary guardian