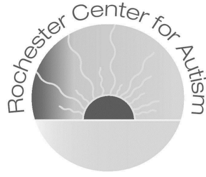
New Student Application



Rochester Center for Autism
3640 9th St. NW
Rochester, MN 55901
507-424-3234

Dear Parents/Guardians,

Welcome to the Rochester Center for Autism! We are grateful that you are interested in our program and look forward to meeting you and your family. The Rochester Center for Autism opened its doors in Rochester, MN in April of 2004. It is a center-based ABA (Applied Behavior Analysis) program that provides one-on-one therapy for children diagnosed with Autism, as well as other Autism Spectrum Disorders. The Center looks to provide quality, caring service to each child that is enrolled. Each staff member is highly trained and dedicated to meet the needs of the families and children they serve.

The first step in enrolling in our program is completing the necessary paperwork for your child. Please thoroughly fill out each page of the student application packet that is provided below. Once you have completed the forms you may submit it by mail, drop it off or fax it to the Center. In addition to the application packet, attach all medical documentation relating to the autism diagnosis (this must include the 5 AXIS) and a copy of your child's insurance card. I will be in contact with you when I receive the application packet to continue the intake process. If you have any questions along the way, please contact me during our scheduled business hours.

Thanks again for your interest in our program!

Sincerely,

Jaclyn Burton

Student Intake Coordinator/Lead Therapist

Rochester Center for Autism

(507) 424-3234 fax (507) 424-3235

jaclynburton@rcautism.com

Patient Registration Information

Start Date __________________ (RCA will fill in)

(Please Print)

Today's Date _________________ Home Phone ______________________________Cell #______________________

E-mail Address for Contact Information____

Patient:

____

Last Name First Name Initial

Street Address: ____

City: ____ State: _________________________ Zip: _________

Sex of child: M___ F___ Age: _______ Birthday _____________ Child's Social Security #:_______________________

Responsible Party (if a minor): ____

Siblings (list names and ages): ____

Mother Employed By: ____

Business Address: ____

Occupation: ____________________________________ Business Phone: ____________________________

Father Employed By: ____

Business Address: ____

Occupation: ____________________________________ Business Phone: ____________________________

Father Social Security #: _____________________________ Mother Social Security #: __________________________

Name of Primary Insurance ____

Member Number____________________ Group Number: ___________________ Subscriber Name________________

Name of Secondary Insurance ____

Member Number: ______________ Group Number: ________________ Subscriber Name: _______________

Medicare #_______________________________ Medicaid #_____________________________

I prefer:
- ___ Pay my balance in full at time of service.
- ___ Pay my balance in full upon receipt of first statement.
- ___ Make payment arrangements prior to services being rendered.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I ____hereby authorize____

(Name of Insured) (Name of Insurance Company)

To pay and hereby assign directly to Rochester Center for Autism all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all changes incurred. I further acknowledge that any insurance benefits, when received by and paid to Rochester Center for Autism will be credited to my account, in accordance with the above said assignment.

____ ____________________

(Authorized signature of Subscriber) (Date)

Patient Registration Information Cont'

Contact Information

Preferred Method of Contact (please rank in order)

Home Phone Number____ Cell Phone Number ____ Work Phone Number____ Email Address____

Additional Information: ____

Emergency Contact Information

Emergency Contact: ____ Phone Number: _______________________

Relationship: _________________________________

Additional Service Providers

Social Worker: ____ Phone Number: _______________________

Address: ____

School: ____

Teacher's Name: ____ Grade: ______________________________

Address: ____ Phone Number: ________________________

Other Providers (if applicable)

Name: ____ Type of Service: _________________________

Address: ____ Phone Number: _________________________

Name: ____ Type of Service: _________________________

Address: ____ Phone Number: _________________________

Medical Background

Does your child have any medical conditions? Yes / No

If yes, please list any special problems such as allergies, existing illness, previous serious illness, injuries during the past 12 months, any medication prescribed for long-term continuous use, and any other information which staff should be aware of.

Patient Registration Information Cont'

Strengths

Please list all of your child strengths such as drawing, writing, computer, etc.

Main Concerns

Please list any concerns the child may have at home or in the community. This may include, but not limited to, sensitivity (i.e. oversensitive to noises, oversensitive to certain material or texture of food), behaviors, communication, social skills and play skills. Additionally, provide any special accommodations that would help staffs to better support the child's progress.

Patient Registration Information Cont'

Possible Reinforcers

Please list all or any preferences that your child has shown and put * next to the ones that are highly preferred in each category. Be SPECIFIC as possible!!

FOOD: (snacks, candies, chocolate – please be specific; kind or brand names)

____
____
____
____

TOYS: (games, stuff animals, etc.)

____
____
____
____
____
____
____
____

PHYSICAL CONTACT: (tickles, hugs, kisses, clapping, back rubs, etc.)

____
____
____
____
____
____
____

ACTIVITIES: (reading books, listen to music, etc.)

____
____
____
____
____
____
____
____
____

OTHERS: (any special preferences not mentioned)

____
____
____
____
____
____
____

Rochester Center for Autism
Consent for Field Trip

I, ________________________, as parent/legal guardian of _____________________, give permission for my child (hereinafter known as “Participant”) to participate in field trips and activities outside of the facility and I have given all necessary emergency contact information to the Center.

I hereby agree to hold harmless and release from any and all liability, the Rochester Center for Autism, its directors, officers, employees, agents, affiliates, sponsors and promoters, as well as their respective directors, officers, employees and agents (hereinafter collectively known as “Rochester Center for Autism and its Sponsors”) for any injury or illness to the Participant arising out of or in connection with their participation in the Rochester Center for Autism field trips which occur outside the premises of the Center. Also, to the fullest extent allowed by law, I hereby waive and discharge my and the Participant’s rights, including those of our heirs and assigns, to any and all claims of damages for injury or illness to the Participant against the Rochester Center for Autism and its Sponsors arising out of or in connection with the Participant’s participation in the Rochester Center for Autism field trips which occur outside the premises of the Center. I agree that health insurance coverage for the Participant is my sole responsibility.

Parent/Guardian Comments:
____
____
____
____

Parent/Guardian Name (please print): __________________________ Date: ________

Parent/Guardian Signature: __________________________________ Date: ________

Rochester Center for Autism
Consent for Video and Picture Release

Child’s Name: ____

Rochester Center for Autism, Inc. has my permission to take pictures of and/or videotape my child while receiving services at the Center. The pictures and/or videos may be used for the purpose of training, reporting, examination and marketing pieces for program awareness.

Pictures and/or video clips may be used as follows:
(Please check those you authorize for use by the Rochester Center for Autism)

____ Poster Boards/Wall Displays
____ Brochures
____ Media Presentations of the ABA Program
____ Program Book Covers
____ Scrapbooks
____ Website

Parent/Guardian Name (please print): __________________________ Date: _________

Parent/Guardian Signature: ___________________________________ Date: _________

Rochester Center for Autism
Service Coordination

Child's Name: ____ Date: ______________

Service Coordination:

Minnesota Statutes governing Children's Therapeutic Services and Supports require providers to coordinate services. If your child is receiving any of the following, indicate the number of hours of service per day and the frequency of the service.

Service	Number of Hours	Frequency
Special Education Services		
Child Welfare- Targeted Case Management (CW-TCM)		
Community Alternatives for Disabled Individuals (CADI) Waiver		
Personal Care Assistant (PCA)		
Mental Health- Targeted Case Management (MH-TCM)		
Recreational Therapy		
Psychiatrist		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Collaborative/Wraparound Services		
Other (explain)		

Rochester Center for Autism
Consent for Exchange of Information

Authorization for exchange of information:

Child's Name: ___________________________

I hereby authorize exchange of information between the Rochester Center for Autism and...(ex. clinic, schools, insurance, social service, etc.). Please list any that pertain to you.

____
____
____
____
____

I understand that I may cancel this consent at any time prior to the information being released.

Parent/Guardian Signature: ______________________________ Date: ____________

Federal Law: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law prohibits disclosing this material. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

Rochester Center for Autism
Consent Form

I, ____________________, as parent/legal guardian of _______________, give permission for my child/ward, (hereinafter "Participant") to participate in the Rochester Center for Autism Early Childhood Program. I have received an enrollment application package and have read, understood and completed all the necessary forms required prior to enrollment. I agree with the current personal development goals established for Participant, and I am aware that I will be required to attend periodic meetings for review and revision of Participant's individual program. I also understand that I may withdraw Participant at any time. I understand that the Rochester Center for Autism reserves the right to terminate the enrollment of Participant for failure to adhere to program standards.

I have given all emergency contact information to the Rochester Center for Autism.

I also give permission for the Rochester Center for Autism to use any necessary information and data collected on Participant to be reviewed and used in presentations at any professional meetings and conferences. I understand that Participant's name and identity will be kept confidential and will not be disclosed without prior written notification. I also understand that this will serve to further the advances in the field of autism.

I hereby agree to hold harmless and release from any and all liability, the Rochester Center for Autism, its directors, officers, employees, agents, affiliates, sponsors, and promoters, as well as, their respective directors, officers, employees, and agents (hereinafter collectively known as "the Rochester Center for Autism and its Sponsors"), for any injury or illness to the Participant, arising out of or in connection with his/her participation in the Rochester Center for Autism program. Also, to the fullest extent allowed by law, I hereby waive and discharge my and the Participant's rights, including those of our heirs and assigns, to any and all claims of damages for injury or illness to the Participant, against the Rochester Center for Autism program. I agree that health insurance coverage for the Participant is my sole responsibility.

Parent/Guardian comments:

____
____
____
____

Parent/Guardian Name (please print): ______________________ Date: _____________

Parent/Guardian Signature: ______________________________ Date: _____________