Florida Institute of Technology
The Scott Center for Autism Treatment

CLIENT REGISTRATION FORM

Client Name _____ Date of Birth _____
Last *First* *Middle Initial*

Parent/Guardian Name (1) _____
Last *First* *Middle Initial*

Parent/Guardian Name (2) _____
(if applicable) *Last* *First* *Middle Initial*

Client's Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Email _____

❑ I give permission for any medical records to be mailed to me at the address listed above.

INSURANCE INFORMATION

Insurance Company _____

Subscriber No. _____ Group No. _____

Policyholders Name _____ Relationship to Client _____

Date of Birth _____ Policyholder's SSN _____ Phone _____

❑ I do not carry insurance and I agree to self-pay any charges I incur.

CLIENT RESPONSIBILITY

Please provide information on who is financially responsible for the client's responsibility and to whom invoices will be mailed.

Name _____ Relationship to Client _____

Mailing Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Email _____

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____ ❑ Add ❑ Remove

Name _____ Phone _____ Relationship _____ ❑ Add ❑ Remove

Name _____ Phone _____ Relationship _____ ❑ Add ❑ Remove

CLIENT CONSENTS AND ACKNOWLEDGEMENTS

_____1. I certify that I am the parent/legal guardian of _____ .
Client's Name

_____2. **Consent for Treatment of a Minor**
I, as the parent or legal guardian of the client, do hereby give my consent and authorize treatment. Furthermore, the named individuals below may, if I am not present, in accordance with the consent communicated by the above individual to Clinicians pursuant to the delegation of my authority granted here, and consistent with the Clinician's professional judgement of my child's medical needs, authorize Clinicians to see, examine and evaluate and treat. This authorization will remain in effect until revoked by me in writing.

Authorized Persons for Treatment of a Minor:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

_____3. **Consent to Bill**
I give permission to have evaluation and assessment services to be billed through my insurance company.

_____4. **Consent for our Third Party Billing Company**
I authorize The Scott Center for Autism Treatment and its third party billing agent, Bronco Billing, to obtain any or all medical records in order to process claims.

_____5. **Notice of Privacy Practices**
I acknowledge that I have received a copy of The Scott Center's Notice of Privacy Practices, which describes the ways in which the proactive may use and disclose my health care information for its treatment and payment/health care operations and other described and permitted uses and disclosures. I understand that I may contact the Operations Administrator if I have a question or complaint. To the extent permitted by the law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy.

_____6. **Summary of the Client's Bill of Rights and Responsibility**
I acknowledge I have received a Summary of the Client's Bill of Rights and Responsibility, and I fully understand all of my rights and responsibilities and agree to comply with the requirements of The Scott Center.

_____7. **HIPAA Consent**
We are unable to give out confidential client information to any party over the telephone or in person without your written authorization. If you wish us to discuss your personal medical information over the telephone or in person with someone other than yourself, we ask that you complete the authorization below. I authorized The Scott Center for Autism Treatment to release my protected health information (PHI) to the authorized person or persons listed below:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

_____8. **Video Consent**
I authorized The Scott Center for Autism Treatment to use videotapes of myself or my child for the following purposes. *Check all that apply:*

❑ For documentation or evaluation
❑ To assist in training professionals
❑ Research purposes
❑ I **do not** consent

_____9. **Video/Photo Consent for Media Purposes**
I authorize Florida Institute of Technology assignees, licensees and legal representatives the irrevocable right to use my child's name, picture, portrait or photograph in all forms and media in all manners including composite or distorted representations for advertising, trade or any other lawful purposes and I waive any right to inspect or approve the finished product, including the written copy that may be created in connection therewith.

❑ I do consent
❑ I **do not** consent

_____10. **Emergency Transportation and Restrictive Procedures Consent**
I understand that in order to maintain client and staff safety and to provide effective behavioral treatment, it may be necessary to use management procedures that involve physical contact with my child. The philosophy of The Scott Center for Autism Treatment is to use the least restrictive alternative necessary, while maintaining safety of all involved. I also understand that it may be necessary to employ emergency transportation and restrictive procedures as a temporary safety precaution. The Scott Center implements procedures based on the behavioral safety training program, Safety Care (www.qbscompanies.com/Safety-Care). Multiple trained supervisors and clinicians are available to assist in the event of a crisis or if de-escalation of problem behavior is required.

❑ I do consent for emergency transportation and safety restrictive procedures.

❑ I **do not** consent for the use of emergency transportation and safety restrictive procedures. I acknowledge that failure to give consent for the use of these procedures may result in my child's inability to receive services.

Client's Name _____ Date of Birth _____

Parent/Guardian Print Name _____ Signature _____

The Scott Center Witness _____ Date _____