FULL CIRCLE PEDIATRIC SOLUTIONS
P: 701-478-0221
F: 701-478-0222

4725 AMBER VALLEY PARKWAY, SUITE B,
FARGO, ND 58104
FULLCIRCLEPEDIATRIC.COM

Welcome to Full Circle Pediatric Solutions!

Our Mission: At Full Circle Pediatric Solutions, we are dedicated to serving children with varying needs and abilities, along with their families, to reach their full potential. We believe in providing high quality, ethical services to allow for individualized growth and to develop lifelong skills by supporting the whole child—full circle.

Please complete this application honestly and accurately in order to ensure a comprehensive assessment of your child. Upon completion, please email it to info@fullcirclepediatric.com or fax it to 701-478-0222. Please call 701-478-0221 if you have questions or need assistance in completing the application. A team member will reach out to you regarding next steps for assessment when it is received. We look forward to working with you and your child!

If you would like to request a translated copy of this form or an interpreter to assist you in completing it, please call 701-478-0221.

Si desea una copia traducida de este formulario o un intérprete que lo ayude a completarlo, llame al 701-478-0221.

Haddii aad jeclaan lahayd inaad codsato nuqul la tarjumay ee foomkan ama turjumaan kaa caawiya buuxinta, fadlan wac 701-478-0221.

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Embracing Our Differences, Empowering Us All

At Full Circle Pediatric Solutions, our commitment to diversity and inclusion is integral to our mission of helping children of varying needs and abilities reach their full potential. Our clients come to us from all walks of life. That's why as we continue to grow and build our team, we actively seek staff with varied backgrounds and experiences. We believe a diverse and inclusive environment empowers us all and are committed to making our clinic a welcoming, supportive place where everyone can thrive.

New Client Intake Process

1. Caregiver will complete the 'First Set of Forms'
    a. Application for Services
    b. Notice of Privacy Practices
    c. Insurance Verification Form
2. Full Circle will electronically send releases of information (ROIs) to caregiver for signature and Full Circle will request records from other service providers
3. If there is a waitlist for ABA therapy, Full Circle will send the caregiver an estimated wait time, a list of other ABA service providers, and options for caregiver training
4. Once there is an ABA therapy opening, Full Circle will verify insurance coverage and notify caregiver of summary of benefits
5. Full Circle will contact the caregiver to schedule the initial intake process
    a. Caregiver interview
    b. In-home or school observation
    c. Additional assessments in the clinic if appropriate
6. The BCBA will write the client's treatment plan and submit to insurance for approval
7. Full Circle will send the caregiver the 'Second Set of Forms' to complete
    a. Client Bill of Rights
    b. Attendance, Tardiness, and Cancellation Policy
    c. Payment Policy and Fee Schedule
    d. Communication Preference Form
    e. Sick Child Policy
    f. Consent for Applied Behavior Analysis (ABA) Therapy
    g. General Acknowledgement of Forms
8. Caregiver(s) will meet with BCBA to review forms, treatment plan, and therapy schedule
9. Caregiver will provide Full Circle with copy of insurance card

FULL CIRCLE
PEDIATRIC SOLUTIONS

Application for Services

Contact Information
Today's Date:
Person completing form:
Relationship to client (child):
Best contact phone number:
Email address:
How did you hear about Full Circle:

Child Information
Child's name (first, middle, last):
Child's preferred name:
Child's date of birth (month, date, year):
Child's age:
Gender:
Custodial Parent(s)/Legal Guardian(s):
Race/Ethnicity:
Primary language spoken at home:
Child's primary language:
Is an interpreter needed for assessment and/or caregiver communication? Yes No

Custodial Parent/Legal Guardian Information		
Parent/Guardian #1		
First Name:	**Last Name:**	**Relationship to Child:**
Street Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Email Address:		
Address same as child? Yes No	**Marital Status:** Single Married Divorced Separated Widowed	
Does this parent have custody of the child? Yes ☐ No ☐	**Type of Custody:**	
Parent/Guardian #2		
First Name:	**Last Name:**	**Relationship to Child:**
Street Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Email Address:		
Address same as child? Yes No	**Marital Status:** Single Married Divorced Separated Widowed	
Does this parent have custody of the child? Yes No	**Type of Custody:**	

Family Information		
Does the child have siblings or are there other siblings in the home(s)? Yes ☐ No		
Child 1 Name:	**Age:**	**Developmental Concerns:**
Child 2 Name:	**Age:**	**Developmental Concerns:**
Child 3 Name:	**Age:**	**Developmental Concerns:**
Child 4 Name:	**Age:**	**Developmental Concerns:**
Child 5 Name:	**Age:**	**Developmental Concerns:**

Is there anything additional you would like to share about the family/home environment:	
Emergency Contact Name (cannot be a parent):	**Phone:**
Emergency Contact Relationship to Child:	
Will anyone else accompany/pick up/drop off your child? Yes No	
If yes, please list caregivers authorized to accompany/pick up/drop off your child during therapy Sessions. This includes DSPs, step-parents, etc. We will send electronic ROIs for you to complete for each of them.	
Name:	**Phone:**
Name:	**Phone:**
Name:	**Phone:**
Name:	**Phone:**
Name:	**Phone:**

Medical Information and History

Current Physician:	**Phone Number:**
Name of Clinic:	**Address:**

Mother's Health During Pregnancy:

1. **Were there any infections or illnesses? Yes No**
   Describe:
2. **Was there any stress during the pregnancy?** Yes No
   Describe:
3. **Were there any complications during labor or delivery? Yes No**
   Describe:
4. **What was the mother's age at the time of delivery?**

Child's Health:

1. **How many weeks gestation was the child born in weeks? (40 weeks is typical)** ☐ ☐
2. **What was the weight of the child at length of the child at birth?**
3. **How was the child delivered? Vaginally Cesarean Section**
4. **Please describe any complications or concerns during labor or delivery:**

Date and Results of Last Hearing Exam:

Date and Results of Last Vision Exam:

Please list any hearing, feeding, swallowing, or gastrointestinal issues now or in the past:
Check and describe all that apply:

Adenoidectomy	**Asthma**	**Behavior Issues**
Brain injury	**Breathing problems**	**Cardiac issues**
Chicken pox	**Diabetes**	**Ear infections**
Ear tubes	**Encephalitis**	**Frequent colds**
High fever	**Measles**	**Meningitis**
Mumps	**Seizures**	**Sensory issues**
Sleep issues	**Tongue tie**	**Tonsillitis**
Tonsillectomy	**Traumatic brain injury**	**Vision issues**

Describe any boxes that were checked:

Has your child ever been admitted to a treatment center or hospital setting for any psychiatric, behavioral, medical, or crisis scenarios? Yes No
If yes, please describe:

Please list any known allergies (including food allergies) or food restrictions:

Does the child currently use any adaptive equipment? (e.g., communication device, walker, etc.)?
Yes No
If yes, please describe:

Developmental History: At what age did the child do the following:

Sit alone:	Combined Words:
Crawl:	Sentences:
Stand Up:	Fed Self:
Walk:	Understood by Others:
Made Sounds:	Toilet Trained:
First Word:	Dressed Self:

Does the child do any of the following:

Choke on liquids	**Choke on foods**
Avoid foods	**Maintain a special diet**
Use a pacifier / suck thumb	**Mouth objects**

Please describe any of the above:

How many words does the child say?
0-20 21-50 51-100 101-150
151-300 301-500 500+

Does the child produce sentences of the following length:
N/A 2 words 3 words 4 words 5+words

What percentage of the child's speech do you understand? %

How well do people outside of the family understand their speech? %

If your child is not using words, how do they communicate?

How does child's communication and/or behavior difficulties impact the family?

Is the child aware of and/or frustrated by their communication difficulties? Yes No

Does the child have any difficulty with the following:
Attention Frustration Tolerance

Aggression	Anger
Answering simple questions	Answering –wh questions
Understanding people	Following directions
Excessive drooling	Chewing or eating
Producing speech sounds	Stuttering
Reading	School work
Remembering	Maintaining eye contact
Transitions	Word Retrieval
Other difficulties:	

Please describe any boxes that were checked:

Child's hand preference?	Right	Left	N/A

Official Diagnosis (list all that apply):

Diagnosis	Date of Diagnosis	Age of Diagnosis	Name of Diagnosing Practitioner

Medications your Child is Currently Taking

Medication	Dosage	Time Given	Take to Treat What Symptom?

Social History

Describe how the child interacts with parents, siblings, or other family members:

Please describe the communication difficulties the child faces in the home environment:

Describe any significant events or changes within the home:

What are the child's strengths?

What are the child's weaknesses?

What are the child's favorite items, activities, and interests? (foods, toys, games, etc.)

Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior?

Does the child become easily frustrated with certain activities? If so, please explain:

Describe how the child interacts with other children:

Is there anything else that is important for us to know about your child?

Educational Information & History
Current School:
District:
Current Grade:
What type of educational environment? General Education Special Education Combination
If this is a special education environment, please describe the amount of inclusion that your child has in the general education environment/exposure to typically developing peers:
Days/Times of attendance:

Evaluation
Has the child previously received speech, language or feeding evaluation / treatment? Yes ☐ No ☐ **If yes, who was the provider?*
Has the child previously received applied behavior analysis therapy? Yes No **If yes, who was the provider?*
Has the child previously received occupational therapy? Yes No **If yes, who was the provider?*

Parent/Guardian Signature Date

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Insurance Verification Form

Client Information (child receiving services)		
Client First Name:	**Middle Name:**	**Client Last Name:**
DOB:	**Gender:**	
Home Address:		
City:	**State:**	**Zip:**

Financially Responsible Party		
Last Name:	**First Name:**	
Home Address (if different than client above):		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Email Address:		

Primary Insurance Full Circle will contact your insurance provider to verify coverage and send a detailed summary of benefits via email.	
Insurance Company:	
Subscriber Name:	**Subscriber's DOB:**
Employer:	**Policy ID:**
Group #:	**Effective Date:**
Phone Number on back of insurance card:	

Secondary Insurance Full Circle will contact your insurance provider to verify coverage and send a detailed summary of benefits via email.	
Insurance Company:	
Subscriber Name:	**Subscriber's DOB:**
Employer:	**Policy ID:**
Group #:	**Effective Date:**
Phone Number on back of insurance card:	

HIPAA POLICY
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We 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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information. The
right to amend your protected health information.
The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services Office of
Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Full Circle Pediatric Solutions is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information maybe used and shared.

I acknowledge that I have received a copy of Full Circle Pediatric Solution's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

I understand Full Circle Pediatric Solutions cannot disclose my health information other than as specified in the notice.

I understand that Full Circle Pediatric Solutions reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement.

HIPAA Privacy Notice Acknowledgement

_____

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: _____

_____ _____

Staff Member Signature Date