New Client Registration

Horizons Behaviour Consulting
Ottawa, Ontario
(613) 601-3911

Thank you for your interest in receiving services from Horizons Behaviour Consulting! To help in the first few steps of the intake process, below is some information about the services that we offer and the intake process.

Filling out the registration form provides us with all the information needed to start services. These forms will provide the behaviour consultants with important information about the client and as such, we require that the additional paperwork be turned in prior to scheduling services. Below we have provided a list of our services and brief descriptions of each to aid in deciding what services you may be interested in:

Applied Behavior Analysis (ABA) Services: Our behavior consultants provide evidence-based treatment based on the principles of applied behavioral analysis (ABA), in order to identify individualized goals to support skill acquisition, to decrease the frequency of challenging behaviors, and to support the individual in a variety of settings. The types of services that are offered include:

- **Focused ABA Services:** The Behaviour Consultant will meet with the parent/caregiver and the child for 2 to 5 hours per week and work on a limited number of behavioural targets (e.g., problem behaviours, functional skills, social skills). Services can typically last anywhere between 4 to 6 months and can be offered through different online platforms if requested (e.g., Skype, Zoom).
- **Comprehensive ABA Services:** The Behaviour Consultant will meet with the parent/caregiver and the child for 20 to 40 hours per week and work on multiple affected developmental domains (e.g., communicative, social, maladaptive behaviours, etc.). Comprehensive services are more intensive than focused services and can typically last anywhere between 6 months to 2 years.

Please thoroughly fill out each page of the registration form that is provided below. Once you have completed the forms, please email it to mderkach@horizonsbehaviourconsulting.com and I will be in contact with you when I receive the registration form to continue the intake process. If you have any questions along the way, please do not hesitate to contact me. We look forward to working with you and your family!

Sincerely,

Matt Derkach, M.ADS, BCBA
Behaviour Analyst
Horizons Behaviour Consulting
Contact: 613-601-3911
www.horizonsehaviourconsulting.com

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Person completing this form

Name: _____
Please indicate relationship to the client: ☐Parent ☐ Guardian ☐ Other: _____

Are you authorized to consent for this individual's healthcare?
_____ No _____ Yes

Client's Legal Name:

_____

Name Client goes by: _____ Date of Birth: _____
Gender: □ M □ F

Home Address:

_____

Family Information

Client lives with: _____

Parent/Guardian 1

Name: _____

Relationship: _____

Address (fill in if different from above): _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____

Cell Phone: _____

E-mail Address:

_____

Employed by: _____

Occupation: _____

Parent/Guardian 2

Name: _____

Relationship: _____

Address: (if different) _____ Province: _____Postal Code: _____

Home Phone: (if different) _____

Cell Phone: _____

E-mail Address

_____

Employed by: _____

Occupation: _____

Names and ages of any other siblings:

_____

Primary language of client: □ English □ Other: specify _____

Percent of time the child is exposed to non-English language(s):

Emergency Contact Information

Please provide the name and phone number of an individual who can be called in case of an emergency when parents/guardians are not available.

Emergency Contact: _____

Relationship: _____

Home Phone Number: _____

Cell Phone Number: _____

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Previous/Additional Service Providers

Has the client ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other mental health counselors?
____ No ____ Yes ___ Unknown

If yes, please provide the following information:

A. Name: _____ Type of Specialist_____
Date started service: _____ Date ended service: _____
Hours per day: _____

Purpose of service:

_____

_____

_____

_____

B. Name: _____ Type of Specialist_____
Date started service: _____ Date ended service_____
Hours per day: _____

Purpose of service:

_____

_____

_____

C. Name: _____ Type of Specialist_____
Date started service: _____ Date ended service_____
Hours per day: _____

Purpose of service:

_____

_____

_____

Medical Information

Hospital/Clinic Preference:

_____

Client's Primary Doctor: _____

Doctor Phone Number: _____

Allergies:

_____

List any medication routinely taken at home:

_____

_____

**An additional *Permission to Administer Medication* form will need to be completed and on file for each specific medication your child takes at Horizons Behaviour Consulting.

List any medical restrictions to client's activities:

_____

_____

List any special dietary needs:

_____

Client's Interests

1. 1. Preferences (favorite activities, food, interests/topics, sensory):

2. Other important information regarding interests:

Concerns

1.Please explain the reasons for seeking ABA services. This may include, but not limited to, sensitivities (e.g., oversensitive to noises, oversensitive to certain material or texture of food), problem behaviors, communication, social skills and play skills.

2. Please list client strengths:

Additional Comments

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Funding

□ Yes □ No (private)

If yes, please indicate the source of funding (e.g., Ontario Autism Program, Children's Aid Society, Insurance, etc.)

_____

_____

_____

_____

Hours of Availability

Please mark the times you and the client ARE available for services.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00am					
9:00am					
10:00am					
11:00am					
12:00pm					
1:00pm					
2:00pm					
3:00pm					
4:00pm					
5:00pm					
6:00pm					

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Cultural Considerations

Please describe below important cultural practices, rituals, traditions or beliefs that you believe are important for us to be aware of prior to beginning services.

_____

_____

_____

_____

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SIGNATURE and ACKNOWLEDGEMENT

By signing, I hereby certify that the above statements are true and correct to the best of my knowledge and understand all information in this packet will become part of the patient's clinical file.

_____ _____

Signature (Parent/Guardian) Date

I hereby confirm that I have reviewed with the parent/guardian the information set forth in this document and understand all information in this packet will become part of the patient's clinical file.

_____ _____

Signature of BCBA Date

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CONSENT FOR COMMUNICATION

Horizons Behaviour Consulting would like to know your preferences by which we may contact you regarding your services.

I do not have a preference, Horizons Behaviour Consulting may contact me using either email or phone ____ No ____ Yes

I prefer the majority of all contact to take place via phone ____ No ____ Yes. If yes, please indicate below best contact number(s):

Home Number: _____ Best time(s) to call: _____

Is it ok to leave a message at this number? ____ No ____Yes

Work Number: _____ Best time(s) to call: _____
Is it ok to leave a message at this number? ____No ____ Yes

Cell Number: _____ Best time(s) to call: _____
Is it ok to leave a message at this number? ____No ____ Yes

I prefer the majority of all contact to take place via email ____No ____ Yes

If yes, please review and sign the consent for email below:

Staff working for Horizons Behaviour Consulting may communicate via email, but this agreement does not obligate staff at Horizons Behaviour Consulting to communicate via email. Email may be one of many forms of communication with staff at Horizons Behaviour Consulting.

<u>Risk of using email</u>

I want to use email to communicate to staff at Horizons Behaviour Consulting about my/the client's personal health care. I understand that staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may impact the privacy of my personal health care information when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Email may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.

- Copies of email may exist after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and analyze emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread different computer viruses.
- Email delivery is not guaranteed.

Understanding the use of email, I give permission for staff at Horizons Behaviour Consulting to send me email messages that include my/the client's personal health care information and understand that my email messages may be included in my/the patient's medical record. I have read and understand the risks of using email as stated above and agree that email messages may include protected health information about me/the client, whenever necessary.

Email address:

_____

Client's name

_____

_____ _____

Signature (Parent/Guardian if under 18yrs old) Date

_____ _____

Signature of client (If client is 13yrs old or over) Date

Please send Registration Form to mderkach@horizonsbehaviourconsulting.com once completed