

Thank you for your recent inquiry about the Greenwood Interprofessional Autism Center. Attached is our Greenwood Intake Packet. Please fill out this packet and return it with all required documents. In order to make sure that all information is current, it is our policy that the intake packet and all required documents must be returned within 90 days to place you/your child on our waitlist and/or scheduling you/your child for an Initial visit. You will not be placed on our waitlist or scheduled until all documents are received by Greenwood.

There are three Authorization of Release of Information (HIPAA) Forms at the end of this Intake Packet. Please fill out one form for Medical, one form for School and one for Therapy(s). If you/your child is currently enrolled in more than one Therapy, please print off an additional Authorization of Release of Information form and fill that out for the additional Therapy(s).

Please note that our email system limits the total size of an email to 20 MB. When sending an email that is larger than 20 MB, including attachments, please divide the email between more than one email.

Disclaimer: Truman's email is HIPAA compliant. Please exercise caution when emailing personal health information from an account outside of Truman's organization.

If you have any questions, or need assistance, please reach out and I would be glad to assist you.

Thank you,



## Greenwood Intake Packet

Hello, thank you for your interest in the Greenwood Interprofessional Autism Center. This packet contains information relating to services here at Greenwood. Copies of the following documents in addition to this completed packet are required in order for us to begin services:

1. Insurance card(s) (front and back)
2. Medical Records (including OT, PT, SLP, ABA or any other therapy records)
3. IFSP or IEP and Evaluation Report (if applicable)
4. Signed permission to treat (if applicable)

If applying for ABA Therapy services only we will also need

5. Autism Spectrum Disorder (ASD) diagnostic report, once you have received an Autism Spectrum diagnosis.
  - a. Acceptable assessments include: ABC, CARS, CHAT/M-CHAT, CSBS-DP-IT-Checklist, ASQ, AQ, CAST, ADI, ADOS, DISCO, STAT
6. Recommendation, prescription or signed coordination of care letter for ABA therapy from the diagnosing physician or primary care physician

Once this packet, and above required documents has been completed and returned to Greenwood, you/your child will be added to our service list and your insurance will be verified. Greenwood staff will contact you to schedule an assessment once your insurance company has approved this service.

This packet and the required documentation can be returned in one of the following ways:

1. Email: [greenwoodintake@truman.edu](mailto:greenwoodintake@truman.edu)
2. Fax: (660) 785 - 7632
3. Mail: 606 S. Halliburton St. Kirksville, MO 63501
4. In person drop-off at the Greenwood clinic
  - a. Hours: Monday - Friday, 8:00 am - 5:00 pm

We are excited to begin these next steps with you!

Thank you,

*Greenwood Interprofessional Autism Center*

## Client Information Form

Client Name: (first) \_\_\_\_\_ (last) \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Current Age \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

### Parent/Guardian 1:

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Main Contact: Y or N

Address: \_\_\_\_\_

Please check here if the above address is also the client's primary residence.

### Parent/Guardian 2:

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Main Contact: Y or N

Address: \_\_\_\_\_

Please check here if the above address is also the client's primary residence.

How did you hear about us? \_\_\_\_\_

List any hygiene, self help or daily living needs, or accessibility needs the client may have that staff should know of (i.e. toileting procedures, diapering, etc.):

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Describe the client's nutritional background and preferences:

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How does the client typically make requests?

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How does the client typically express themselves / communicate with others?

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Describe the client's current social skills and any concerns in this area (if applicable):

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Describe any cultural or religious preferences that staff should be aware of when working with the client:

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Describe the client's living situation and if there is a current custody arrangement (if the client is in state custody, please attach a signed permission to treat):

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In the following space, please give us some insight into things the client enjoys or does not enjoy.

Preferred Reinforcers, Topics of Interest,  
Enjoyable Activities / Items

Dislikes, Aversive Items, Things to Avoid,  
Activities / Items not enjoyed.

Describe the client's daily routine or current schedule:

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# Medical Case History Form

## Background Information

Describe any ongoing behavioral concerns:

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Describe any ongoing skill deficit or other concerns:

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## Medical History

List any current medical conditions:

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Please indicate if you/your child have been diagnosed with any of the following (check mark):

<input type="checkbox"/>	Attention Deficit/Hyperactivity Disorder	<input type="checkbox"/>	Seizures/convulsions
<input type="checkbox"/>	Obsessive Compulsive Disorder	<input type="checkbox"/>	Neurological disorders
<input type="checkbox"/>	Oppositional Defiance Disorder	<input type="checkbox"/>	TBI
<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	Genetic/Chromosomal disorders
<input type="checkbox"/>	Speech/language disorders	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Anxiety disorders	<input type="checkbox"/>	Learning disability
<input type="checkbox"/>	Mood/personality disorders	<input type="checkbox"/>	Psychiatric disorders
<input type="checkbox"/>	Feeding issues	<input type="checkbox"/>	Gastrointestinal problems
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Sleep issues/disorders
<input type="checkbox"/>	Inquiring for Autism Spectrum Diagnosis at the following facility; _____		

Describe any conditions listed above, or indicate if there is a family history of any of the listed conditions:

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List current allergies (environmental, food, medications, etc.):

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List any current medications:

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Describe any previous surgeries or accidents:

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Describe any previous treatments or therapies and the provider(s) (including but not limited to: ABA services, speech/language services, psychiatric counseling, occupational or physical therapies, First Steps, etc.):

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List current medical providers and their contact information:

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## Developmental/Educational History

Describe any developmental problems during infancy or early childhood (i.e. late in walking, feeding problems, delayed talking, etc.):

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Describe any learning or reading problems currently or previously experienced:

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Please check if your child currently has an IFSP or IEP: \_\_\_\_ Yes \_\_\_\_ No  
If yes, please attach a copy.

List or describe any other medical, developmental, or educational concerns:

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## Diagnostic Information

If you/your child has an Autism Spectrum Disorder (ASD) diagnosis:

Date of Diagnosis: \_\_\_\_\_ Location: \_\_\_\_\_

Diagnosing Practitioner: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

## Current Care Provider

Primary Care Physician: \_\_\_\_\_ Location: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

## Insurance Verification Form

**\*\*If the client has medical coverage under a parent's commercial insurance, this will be the Primary Funding Source. If the client also has a form of Medicaid coverage this will be the Secondary Funding Source. If the client only has a form of Medicaid coverage this will be the Primary Funding Source. If you have both commercial insurance and medicaid for your child, we will need all of this medical insurance information.\*\* If you have any questions concerning this, please call us at 660-785-7551.**

Primary Funding Source: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Employer: \_\_\_\_\_

Member ID/DCN #: \_\_\_\_\_ Group #: \_\_\_\_\_

**\*\*Complete below information if applicable\*\***

Secondary Funding Source: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

Leave blank and check here if the subscriber's address is the same as the address listed above.

Relationship to Client: \_\_\_\_\_ Employer: \_\_\_\_\_

Member ID/DCN #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Guarantor (Person responsible for payment) for copays and deductibles.

\_\_\_\_\_

Is there anyone else who should receive a copy of this client's billing statement? \_\_\_\_\_

If yes: Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

**\*\*By signing below, you are authorizing Greenwood staff to conduct a verification of benefits to confirm funding for the listed funding source(s) above, and to bill the listed funding source(s) for services.\*\***

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorization for Release of Information

**To: Facility/Practice:** \_\_\_\_\_

**Address:** \_\_\_\_\_

I hereby authorize disclosure of confidential health information/records from the above Facility.

I have full knowledge and understand that:

1. By signing this Authorization, I am authorizing the release of confidential health information/records pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to the above-referenced agent(s) of Truman State University.
2. By signing this Authorization, I am requesting and allowing the release of confidential health information/records to the above-referenced agent(s) of Truman State University.

By signing this Authorization, I understand that the specific information to be disclosed may include information regarding (a) drug and alcohol abuse or use of such; and (b) counseling referrals. Moreover, I fully understand that this information is specifically protected by federal regulations including 42 CFR 2<sup>1</sup> and that by signing this authorization I am allowing the release of any drug and/or alcohol information records and/or counseling referrals to the above-referenced agent(s) of Truman State University.

I am aware of the following rights:

1. By signing this Authorization, I understand that there is a potential that information disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this Authorization.
3. I understand that I can revoke this Authorization at any time, except to the extent that action has already been taken in reliance upon it. I understand that any revocation of this Authorization must be in writing and must be addressed to the Greenwood Interprofessional Autism Center.

I hold the above named institution harmless from any and all damages, which might result, to myself and to my relatives or heirs from the use of this information being disclosed to the above-referenced agent(s) of Truman State University.

This Authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined while current client and after discharge from services at Greenwood. This Authorization also includes the authority to copy and inspect any and all such records. A copy of this Release shall be considered to have the same authority as an original.

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<sup>1</sup> *THE FOLLOWING APPLIES ONLY TO DRUG AND/OR ALCOHOL ABUSE/TREATMENT INFORMATION RECORDS published in Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR 2) prohibit you from making 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.*

**Description of information to be provided (check all that apply)**

- Treatment records (including psychological, physical, occupational, behavior analytic, and speech therapies)
- Medical records
- Educational/Evaluation/assessment/eligibility records/IEP/Diagnostic Reports
- Other: \_\_\_\_\_

Such information shall be provided to the following individuals:

Greenwood Interprofessional Autism Center  
Truman State University  
606 South Halliburton St., Kirksville, MO 63501  
P: (660) 785 - 7551  
F: (660) 785 - 7632

**Information is to be restricted to:**

Name of Client/Child: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

The purpose of this release is for coordination of care which is in effect while you are a current client with Greenwood Interprofessional Autism Center unless otherwise indicated.

**Client/Guardian Signature & Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

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4. By signing this Authorization, I understand that there is a potential that information disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
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<sup>2</sup> THE FOLLOWING APPLIES ONLY TO DRUG AND/OR ALCOHOL ABUSE/TREATMENT INFORMATION RECORDS published in Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR 2) prohibit you from making 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.

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**Printed Name:** \_\_\_\_\_

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6. By signing this Authorization, I am requesting and allowing the release of confidential health information/records to the above-referenced agent(s) of Truman State University.

By signing this Authorization, I understand that the specific information to be disclosed may include information regarding (a) drug and alcohol abuse or use of such; and (b) counseling referrals. Moreover, I fully understand that this information is specifically protected by federal regulations including 42 CFR 2<sup>3</sup> and that by signing this authorization I am allowing the release of any drug and/or alcohol information records and/or counseling referrals to the above-referenced agent(s) of Truman State University.

I am aware of the following rights:

7. By signing this Authorization, I understand that there is a potential that information disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
8. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this Authorization.
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**Description of information to be provided (check all that apply)**

- Treatment records (including psychological, physical, occupational, behavior analytic, and speech therapies)
- Medical records
- Educational/Evaluation/assessment/eligibility records/IEP/Diagnostic Reports
- Other: \_\_\_\_\_

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