Participant Application

Email:
info@secondnaturesocialskills.com
Phone: 508.747.2663
Address: 29 South Park Avenue, Plymouth, MA, 02060

Date: _____/_____/_____

Name
_____

Age _____ Date of Birth _____ Gender: Male Female

Primary Language: _____

Parent's Name:_____

Address:
_____

Phone _____ Email:
_____

Emergency Contact Person: _____

Emergency Contact: (Home): _____

Emergency Contact: (Cell): _____

Which number do you prefer us to try first while your child is with us? ***Circle One: Home/Cell***

Please list any allergies or accommodations needed in order to participate.

To participate in Individual and Group Services, please submit the following:

_____Completed Enrollment Packet___Copies of all recent evaluations_____Enrollment Fee

Parent/Guardian Signature
_____Date____/_____/____

Case History

Participant Name:	
Form Completed by:	**Relationship to Participant:**
Date Completed:	

Background Information

Current School:	
Parent 1: **Age:** **Occupation:** **Highest Grade Completed:**	**Parent 2:** **Age:** **Occupation:** **Highest Grade Completed:**
Parents: married living together separated divorced deceased: parent 1 or 2	
Current Grade:	
Level of Inclusion:	
Counseling/Therapy: type, frequency	
Present Medications:	

Parent/Guardian Signature

_____Date____/_____/____

Participant lives with:

Both parents **One Parent** **Other(specify)** _____

Siblings:
1.
2.
3.

Please specify the family members that have been diagnosed with the following (e.g. Father, Mother, Maternal Aunt, Paternal Uncle, Cousin, etc.):

Attention Disorders:
_____

Behavior Challenges:_____
_____

Emotional Challenges:_____
_____

Learning Challenges:
_____

Hearing Problems:
_____

Autism Spectrum Disorder:
_____

Speech and Language Challenges:
_____

Intellectual Impairments:
_____

Neurological Disorders:
_____

Seizure Disorders:
_____

Tic Disorders:
_____
____

Anxiety Disorders:
_____

Other:
_____
_____

Current Behavioral Concerns:

Discipline Information at home:
Who predominately provides the discipline
Both parents **One Parent** **Other(specify)** _____

Type of discipline procedures (e.g. timeout, additional chores, withholding privileges, etc.)

We hold this and all information in the strictest confidence. Providing this information gives us a better understanding of your child and their individual needs.

Parent/Guardian Signature
_____Date____/_____/____

Social Development

Which Most Accurately Describes your child:
0: Never 1: Occasionally 2: Sometimes 3: Frequently 4: Always
Questions:

- **Does your child get along with other children? Explain:**
- **Does your child get along with his/her siblings? Explain:**
- **Do your child's special interests interfere with socialization? Explain:**
- **Has your child experienced bullying? Explain:**
- **Does your child prefer to play or work alone? Explain:**
- **Does your child have an understanding of authority figures? (e.g. behaves with adults. Explain:**
- **Does your child understand and apply Time Management? Explain:**
- **Is your child easily frustrated? Explain:**
- **Does your child work well within a group setting? Explain:**
- **Is your child involved with extracurricular activities? Explain:**

Parent/Guardian Signature

_____Date____/_____/____

Therapeutic Services:

Name of Provider: _____**Service Provided:**_____

Contact Information:
_____

Signature of Consent to Contact:_____

Name of Provider: _____**Service Provided:**_____

Contact Information:
_____

Signature of Consent to Contact:_____

Name of Provider: _____**Service Provided:**_____

Contact Information:
_____

Signature of Consent to Contact:_____

Name of Provider: _____**Service Provided:**_____

Contact Information:
_____

Signature of Consent to Contact:_____

Important: Include a copy of the attendee's most recent evaluation that include, but are not limited to Neuropsychological/Neurology Evaluations, Speech and Language Evaluations, Occupational Therapy Evaluations. If no therapeutic services are provided place an "NA" on the lines above.

Parent/Guardian Signature
_____Date____/_____/____

Insurance Reimbursement Form

Client Information:

Name: _____

Date of Birth: _____**Gender:** _____

Address: _____

City: _____ **State:** _____**Zip:**_____

Home Phone Number: _____

Diagnosis: _____

Insured's Information:

Insurance Company: _____

Identification Number: _____

Group/Plan Number: _____

Employer: _____

Insured's Name: _____ **Insured's date of Birth:** _____

Insured's Gender: _____**Insured's Email:** _____

***Please provide us with a copy of the front and back of your insurance identification card.**

Parent/Guardian Signature

_____Date____/_____/____

How did you hear about Second Nature Social Skills (please circle one)?

a. **Referral from another participant's family**
b. **AANE (The Asperger/Autism Network)**
c. **Internet Search**
d. **Referral from another source (please name):**_____
e. **Other:**_____
_____

What are at least three things you would like us to focus on?

1. _____

2. _____

3. _____

Please include a copy of the attendees most recent evaluations with this application. Place an NA on line if your child does not have the evaluation.

Relevant evaluations include, but are not limited to:

_____**Neuropsychological/Neurology Evaluations**

_____**Speech and Language Evaluations**

_____**Occupational Therapy Evaluations**

_____**Individual Education Plans (IEPs)and/or 504 Plans**

_____**Functional Behavioral Assessment (FBA)**

Parent/Guardian Signature

_____Date____/_____/____

Second Nature Programming

***Please place an NA and sign the bottom of this page if it does not apply**

Choose Session Second Nature Social Skills reserves the right to combine or change group times at any time prior to starting a group. We will try our best to accommodate to your schedule.

Please circle the session or sessions you would like your child to attend. Sessions may be added throughout the year if space is available.

Fall Session	**Winter Session**	**Spring Session**
(Sept-Dec)	(January-March)	(April-June)

Winter Session- *1.5 hours virtual or 2 hours in person sessions (time varies by age of participant) 3rd Saturday of the Month Community Outing (2 hours and depends on the State and Local Board of Health (BOH) guidelines).*

Outing will be sent out via email by Lead Teacher the week of the event.

Winter Group Schedule:

Saturdays: January 9, 16, 23, 30 February 6, 27, March 6, 13, 20, 27, April 3, 10

9:00 a.m. - 10:30 a.m.: Girl's Group
9:30 a.m. - 11:30 a.m.: Upper Elementary/Middle School Group
10:00 a.m. - 11:30 a.m.: Middle School Group
10:00 a.m. - 11:30 a.m.: Teen School Group

Tuesdays: January 5, 12, 19, 26, February 2, 9, 23, March 2, 9, 16, 23, 30, April 6, 13

5:00 p.m. - 7:00 p.m.: Teen and Young Adult Group ACT/ABA based

Thursdays: January 7, 14, 21, 28, February 4, 11, 25, March 4, 11, 18, 25, April 1, 8, 15

4:30 p.m. - 6:30 p.m.: Mixer Group-ACT/ABA based

Parent/Guardian Signature

_____Date____/_____/____

Participant Application: Individual Services

First Name:_____Last Name:_____

Age:_____Date of Birth:_____ Gender: Male Female

Parent's Name:_____

Address:_____

Phone:_____Email:_____

Which number do you prefer us to try first while your child is with us? ***Circle one:***

Home / Cell

Please list any allergies or accommodations needed to participate:

_____
_____
_____

Individual Services (please provide up to 3 time choices):
Second Nature Social Skills© reserves the right to combine or change individual services times at any time prior to starting services. We will try our best to accommodate to your schedule

Monday	***Tuesday***	***Wednesday***	***Thursday***	***Friday***
1st choice:	1st choice:	1st choice:	1st choice:	1st choice:
2nd choice:	2nd choice:	2nd choice:	2nd choice:	2nd choice:
3rd choice:	3rd choice:	3rd choice:	3rd choice:	3rd choice:

Applicant Information (please check one):

_____ EXISTING Applicant

_____ NEW Applicant *(**A one-time $60 enrollment fee applies*).*
The fee includes a record review, interview, & informal evaluation to best inform your child's placement needs.
Due at the time of application

Parent/Guardian Signature
_____Date____/_____/____

Payment Option (please check one):

$120.00 per hour of instruction BCBA level

$60.00 per hour of instruction ABA Specialist/RBT Tech Level

_____ **Weekly:** Full payment rendered at time of service

_____ **Bi-Weekly:** Payments rendered twice per month

_____ **Monthly:** Payment rendered once per month

******The cost of your child's program may be covered by some insurance plans for our clients with an Autism Spectrum Disorder Diagnosis. If you are seeking insurance reimbursement, please fill out our Insurance Reimbursement Form found on our registration page. In order to verify benefits with your insurance company, we will need that, along with a copy of the front and back of your insurance card, and a Doctor's note stating your child's diagnosis and the need for Social Skills Instruction using the ABA model.***

****** Please note, that you will be responsible for all costs not covered by your insurance including co-pays or co-insurance, as applicable. Co-Pays and/or Co-Insurance are due at the time of service. In addition, we require 24 hours' notice for any absences. If we do not receive 24 hours' notice, you will be responsible for the daily program-based fee.***

Parent/Guardian Signature

_____Date____/_____/____

Email: info@secondnaturesocialskills.com
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HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(M.G.L. c. 111, § 70F)
(M.G.L. c. 111, §70G)
(42 CFR, Part 2)

1. Authorization

I authorize _____ (healthcare/ABA provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from: a. □ _____ to _____.

OR

b. □ all past, present, and future periods

3. Extent of Authorization

A. □ I authorize the release of my complete health/educational record (including records relating to behavioral health/pragmatic therapy/educational care,).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Behavioral health/ABA information
□ Educational information
□ Pragmatic Therapy
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for therapeutic treatment or consultation, billing or claims payment, or other purposes as I may direct.

Parent/Guardian Signature

_____Date____/_____/____

5. This authorization shall be in force and effect until _____ (date Or event). At that time, these authorizations will expire.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative

_____ _____
Printed name of patient or personal representative Relationship to Patient

_____
Date

Parent/Guardian Signature
_____Date____/_____/____

Applied Behavior Analysis (ABA)
Group Parent Training Confidentiality Form

I, _____, understand and will comply with the confidentiality clause at Second Nature Social Skills' support/training groups. In these group trainings, I may hear events or situations from other families and /or share my own situations and events with other families.

Being confidential means, what is said or spoken in our group trainings remains private and does not leave the group. It means not sharing information or retelling information that I have heard within the group setting to others. What happens in the group trainings stays in the group trainings. Any written information seen may not be shared or repeated as well.

This group training is a supportive environment and when we are sharing our stories with another, we are empowering ourselves and building solidarity with one another. By signing this form, I am acknowledging and accepting the confidentiality clause for being of the Applies Behavior Analysis (ABA) Group Parent Training.

Parent/Guardian Signature

_____Date____/_____/____

second nature
SOCIAL SKILLS

Parent/Legal Guardian Waiver, Release and Responsibility Form

Please read carefully and initial next to each section and sign and date the bottom of the page.

_____A. General Liability Waiver

I, _____, being the parent/guardian of _____, do hereby consent to his/her participation in voluntary projects and functions sponsored and /or organized by Second Nature Social Skills, its members, and its staff (hereafter referred to as Second Nature. I understand that he/she is responsible for his/her behavior. I do hereby waive and release Second Nature, their service partner (including schools) and or sponsors of any project, event, or function, from all claims and liabilities, of any kind whatsoever, arising from, whether directly or indirectly, my child/ward's participation in Second Nature organized and/or sponsored projects or functions.

_____B. Transportation Liability Waiver

I do hereby consent to Second Nature providing transportation (in private vehicles) for my child/ward if necessary. I understand this service is not guaranteed. I do hereby waive and release Second Nature their service partners and/or sponsors of any project or function, from all claims and liabilities, of any kind whatsoever, arising from, whether directly or indirectly, my child/ward's involvement in transportation services provided by Second Nature.

_____C. Release to Seek Medical Treatment *

In the event of a medical emergency, I do hereby consent to Second Nature releasing my child/ward to the nearest, most appropriate medical professional available. I understand that Second Nature will notify me of such an event immediately after they have sought proper medical treatment for my child/ward. Second Nature should contact me at the following phone number: _____.

If your child/ward has a chronic or recurring condition, for which emergency treatment is not necessary, please discus your child's /ward's needs with Second Nature directly.

_____D. Photo/Video Release

I hereby grant Second Nature permission to use my child's/ward's likeliness in a photograph/video in any of its publications, including website entries, without payment or any other compensation. I understand and agree that these materials will become property of Second Nature and will not be returned.

_____E. Video Release

I hereby grant Second Nature permission to use my child's/ward's likeliness in a video for educational purposes. I understand that it will be shared and reviewed with other video participants, the video participant's parents/guardians, Second Nature Educators, and attendees at Second Nature sponsored educational events.

_____F. Group Commitment and Responsibility

Our staffing and financial commitments are based on client's registrations; therefore, I understand that I am responsible for full payment of the entire group session (winter, spring, summer, or fall) regardless of missed sessions. For planning purposes and for the other group participants, I agree to give at least 24 hours advance notice, via telephone/email, if my child/ward is going to miss a session.

_____G. Insurance Based Clients

I understand that I am responsible for the daily program-based fee if I fail to provide Second Nature with 24 hours advance notice via telephone/email of my child/ward's absence.

By signing below, I indicate that I understand and agree to the items initialed above.

Parent/Guardian Signature

_____Date____/_____/____