	<p>29 South Park Avenue Plymouth, MA 02360</p> <p>Info@secondnaturesocialskills.com</p>	<p>508.747.2663 (office)</p> <p>508.746.3670 (facsimile)</p>
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## Participant Application

Date: \_\_\_/\_\_\_/\_\_\_

*\*Please place NA if it does not apply*

**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**

**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 \_\_\_/\_\_\_/\_\_\_

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## Case History

<b>Participant Name:</b>	
<b>Form Completed by:</b>	<b>Relationship to Participant:</b>
<b>Date Completed:</b>	

## Background Information

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


Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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<p><b>Participant lives with:</b></p> <p><b>Both parents</b>                      <b>One Parent</b>                      <b>Other(specify)</b></p> <p>_____</p>		
<p>Siblings:</p> <p>1.</p> <p>2.</p> <p>3.</p>		
<p>Please specify the family members that have been diagnosed with the following (e.g. Father, Mother, Maternal Aunt, Paternal Uncle, Cousin, etc.):</p> <p><b>Attention Disorders:</b></p> <p>_____</p> <p><b>Behavior Challenges:</b>_____</p> <p><b>Emotional Challenges:</b>_____</p> <p><b>Learning Challenges:</b></p> <p>_____</p> <p><b>Hearing Problems:</b></p> <p>_____</p> <p><b>Autism Spectrum Disorder:</b></p> <p>_____</p> <p><b>Speech and Language Challenges:</b></p> <p>_____</p> <p><b>Intellectual Impairments:</b></p> <p>_____</p> <p><b>Neurological Disorders:</b></p> <p>_____</p> <p><b>Seizure Disorders:</b></p> <p>_____</p> <p><b>Tic Disorders:</b></p> <p>_____</p> <p><b>Anxiety Disorders:</b></p> <p>_____</p> <p><b>Other:</b></p> <p>_____</p>		
<p><b>Current Behavioral Concerns:</b></p> <p>_____</p>		

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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<p><b>Discipline Information at home:</b>  <b>Who predominately provides the discipline</b>  <b>Both parents          One Parent          Other(specify) _____</b></p>
<p><b>Type of discipline procedures (e.g. timeout, additional chores, withholding privileges, etc.)</b></p>    
<p><i>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.</i></p>



**Social Development**

<p><b>Which Most Accurately Describes your child:</b>  <b>0: Never   1: Occasionally   2: Sometimes   3: Frequently   4: Always</b>  <u>Questions:</u></p> <p><input type="checkbox"/> <b>Does your child get along with other children? Explain:</b></p> <p><input type="checkbox"/> <b>Does your child get along with his/her siblings? Explain:</b></p> <p><input type="checkbox"/> <b>Do your child's special interests interfere with socialization? Explain:</b></p> <p><input type="checkbox"/> <b>Has your child experienced bullying? Explain:</b></p>
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Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



**29 South Park Avenue  
Plymouth, MA 02360**


**Info@secondnaturesocialskills.com**

**508.747.2663 (office)**

**508.746.3670 (facsimile)**

- 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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**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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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**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 values you would like to see put into action during our collaborative time together?**

- 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

**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 \_\_\_\_/\_\_\_\_/\_\_\_\_



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## Second Nature Programming

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

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

**Fall Session**  
(September-December)

**Winter Session**  
(January-March)

**Spring Session**  
(April-June)

## Current Club Offerings

*There may be additional program fees beyond the administrative fees attached to this programming*

### 3:45pm-4:45pm Club Offering: Mondays

- o Homework Help/STEAM Club (Science, Technology, Engineering, Art, and Math)


### 4:45pm-6:45pm Club Offering: Wednesdays

- o Homework Help/Dinner Club (offsite and a minimum of \$5.00 needed if purchasing food/drinks)

### 7:00pm-9:00 pm Second Nature Café: Fridays Nights

- o Themed teen and young adult events that is planned for by the participants. Let's Just Be in a safe space that is built in kindness and acceptance as soon as you walk in the door. Each week's event is planned out for the month. Events could be Table/board game nights, takeout and discussion, movie nights, anime inspirations, Lego of My Ego and Chill Fest, and More...

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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## Participant Application: Individual Services

**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*

<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>
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.*

***\*\*\*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 \_\_\_\_/\_\_\_\_/\_\_\_\_

	<p align="center"><b>29 South Park Avenue Plymouth, MA 02360</b></p> <p><b>Info@secondnaturesocialskills.com</b></p>	<p><b>508.747.2663 (office)</b></p> <p><b>508.746.3670 (facsimile)</b></p>
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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.

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

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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## **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, you may hear events or situations from other families and /or share your 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 you 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 Applied Behavior Analysis (ABA) Group Parent Training.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

	<p align="center"><b>29 South Park Avenue Plymouth, MA 02360</b></p> <p><b>Info@secondnaturesocialskills.com</b></p>	<p><b>508.747.2663 (office)</b></p> <p><b>508.746.3670 (facsimile)</b></p>
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## 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 discuss 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 likeness 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 likeness 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

	<p><b>29 South Park Avenue Plymouth, MA 02360</b></p> <p><b>Info@secondnaturesocialskills.com</b></p>	<p><b>508.747.2663 (office)</b></p> <p><b>508.746.3670 (facsimile)</b></p>
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**\_\_\_H. Physical Exam and Immunization (Public School and/or Public Health requirements)**

I certify that documentation of a physical exam and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements, are on file at my child's/ward's/self's school.

**\_\_\_I. COVID-19 Screening**

I certify that I will perform a COVID-19 Screening will be done each day prior to my child/ward/self attending the program, including but not limited to a temperature check.

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

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_