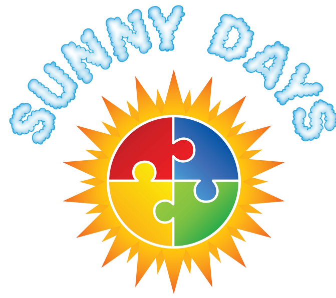

Sunny Days is excited and thankful for the opportunity to provide your child with therapy services! We provide both individual and group therapy and instructional services to children from the ages of 2 – 17 years old. We are committed to providing our families with the most comprehensive and integrated care.

Thank you for entrusting us with your child and for joining Sunny Days in its mission to provide a brighter future for autism!

REQUIRED DOCUMENTATION:

Please note we will process your request for services only after you provide our office with *ALL* of the required documentation. Please sign and complete all of the following to help us better serve you and your child:

1. Intake and Records Release Form.
2. Client Agreement.
3. Insurance card(s) – front and back.
4. Your child's medical diagnostic/psychological evaluation – this document includes many pages detailing a summary of your child's milestones, family history, and diagnoses and recommendations regarding where to get assistance.
5. Prescription(s) for ABA therapy services.

Please feel free to contact us, and we will be glad to assist you! We look forward to working with you and your child! You may submit the required documentation to Sunny Days Behavioral Therapy, L.L.C by email, fax, or mail to the following:

____

Kayla M. Bonano, Clinical Director
Sunny Days Behavioral Therapy, L.L.C.
1109 Business 190, Suite C
Covington, LA 70433
Phone: (985) 260-2776
Fax: (985) 590-5030
Email: kayla@sunnydaysbt.com

INTAKE FORM & RELEASE

Client's Name (Minor): ____

Date of Birth: _____________ Sex: M ___ F ___ SSN ______________________

Diagnoses: ____

Diagnoses Given By: ____

Mother's Name: ____________________ Father's Name ______________________

Marital Status: Married ___ Divorced ___ Single ___ Child Lives With: ____________

If Divorced, are there any relevant court orders in effect? Yes _____ No _____
(If yes, please provide a copy)

Siblings (Please notate age): ____

____

Languages Spoken in the Home: ____

Pets in the Home: ____

Residential Address: ______________________________ Gate Code for Entry: ______

City: ______________________________ State: ____________ Zip: ____________

2nd Residential Address: _________________________________ Gate Code: ______

City: ______________________________ State: ____________ Zip: ____________

Mailing Address: _______________________________________ Gate Code: ______

City: ______________________________ State: ____________ Zip: ____________

Home Phone: ____

Mother's Work Phone: ________________ Mother's Cell Phone: _________________

Mother's Email Address: ____

Father's Work Phone: ________________ Father's Cell Phone: __________________

Father's Email Address: ____

Emergency Contact Name: ____

Relationship: ___________________________ Phone: _____________________________

Please list any chronic or infectious disease, allergy, special diet, or medication (incl. vitamins and herbal supplements) relevant or applicable to your child:

____

____

____

____

____

Please describe, in detail, anything else you believe we should know about your child:

____

____

____

Please describe, in detail, anything you believe we should know about your child's home or intervention environment:

____

____

____

Services Requested: ABA ___ Social Skills ___

SCHEDULE AVAILABLITY:
(Please list the times you would prefer to have services, and Sunny Days will try to accommodate your needs as best as possible)

____

____

____

AUTHORIZATION TO RELEASE INFORMATION AND RECORDS

Communication with your insurance provider, child's diagnosing physician, and schools can be vital to helping us better provide care to your child. Please provide contact information, including name, number, and address, for the following:

DIAGNOSING PHYSICIAN:

Name: ____

Address: ____

Phone: ____

*(*Sunny Days will not contact the physician without parental consent)*

INSURANCE INFORMATION:
(Please include a copy of the front and back of your child's insurance card)

Insurance Company: ____

Name of Insured: ____

SCHOOL INFORMATION:

School District: ____

School: ____

Phone: ____

I hereby understand and acknowledge all of the following, and I hereby authorize Sunny Days Behavioral Therapy, L.L.C. including any authorized designees thereof ("Sunny Days"), to contact, to request records, and to release records to or from my child's providers and schools:

1. Copies of all medical information including but not limited to psychiatric or psychological records, drug or alcohol abuse records, detoxification or rehabilitation records, charts, diagnostic tests, diagnostic records and/or reports, discograms, myelograms, CT scans, x-rays and x-ray reports, opinion letters, surgical reports, laboratory records or reports, pathology records or reports, pharmaceutical records, consent forms, admission and discharge forms and records, financial records showing

charges and payments for services rendered, and for any other medical information which may be relevant for any purpose and at any time.

2. I understand the information in such health records may include information relating to behavioral or mental health services, treatment for alcohol and drug abuse, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

3. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so <u>in writing</u> and present my written revocation to Sunny Days. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the termination of your agreement to receive services from Sunny Days.

4. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed as provided by law. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

I, _____________________, Parent and/or Legal Guardian of _____________________, hereby authorize Sunny Days to contact, to request and obtain records, and to release records to or from my child's health care providers and schools as provided herein.

Additionally, I authorize Sunny Days to release information relative to my child's records, therapy, and treatment plans as necessary to any insurance provider(s).

_________________________________ _________________________________

Parent and/or Legal Guardian Signature Date

Printed Name: _____________________