2020 Social Skills Application Packet

Please complete and return the following forms and be prepared to pay the necessary intake fee on the first day of classes

- Client Information Form
- Stress Response Evaluation
- Scheduling Preference Form
- Parental Consent
- Billing Agreement
- Photograph and Billing Release Form

Forms can be faxed, e-mailed, or turned it at the front office

Fax number: (678)-749-7611

E-mail: Lindsay@mindmotioncenters.com and Elizabeth@mindmotioncenters.com

Once the packet has been completed and you are notified that your information has been received and your child has been matched with a group: intake fees can be paid in office, over the phone, or on the first day of social skill classes.

For additional information, please contact:
Lindsay Hancock, COTA/L Lindsay@mindmotioncenters.com
Liz Pupillo, COTA/L Elizabeth@mindmotioncenters.com
Phone: 678-749-7600 ext. 114

Today's Date: _____

Child's Name: _____

Date of Birth: _____

Address: _____

_____

_____

Email Address: _____ Phone _____

_____

Emergency Contact Name and Phone Number: _____

School Name and District/City: _____

Grade or Equivalent: _____

Diagnosis (if any): _____

What kind of class does your child attend? (Please circle all that apply)

1 – Regular Education/Fully Mainstreamed
2 – Regular Education with Supports (Aide, 504 Plan, Other_____)
3 – Resource Room (If so, what subjects____)
4 – Self-Contained Class
5 – Special Education School
6 – Homeschool

Is your child receiving any additional services? (Please circle all that apply)

1 – Discrete Trial or ABA Home Program
2 – School/Private Speech Therapy
3 – School/Private Occupational Therapy
4 – Other _____

Does your child exhibit any aggressive behaviors? (Self-injurious, hitting, biting or verbal threats)

_____

Does your child have any serious allergies that we should be aware of?

_____

1) Please provide a short narrative describing your child.

_____

_____

_____

2) What are your child's strengths?

_____

_____

_____

3) What are your immediate goals for your child? What do you hope to achieve by utilizing the Social Skills program?

_____

_____

4) What recommendations, if any, have you received from clinicians, teachers or other professionals regarding your child's need for social skills remediation?

_____

_____

5) Please share any other information that you feel will be helpful to us in working with your child/family.

_____

Stress Response Evaluation

How does your child usually indicate he/she is becoming anxious or stressed? Check all that apply and add details as needed.

	Asks inappropriate questions/makes inappropriate comments
	Leaves seat/room
	Becomes off task
	Meltdown
	Becomes silly
	Noises/humming
	Blurts/Yells out
	Reduces eye contact
	Cries/tearful
	Refuses requests
	Damages property
	Repeats self
	Distractibility increases
	Shuts down
	Facial expression/posture changes
	Stares off
	Fidgeting/restlessness
	Voice tone/volume changes
	Hurts self/others
	Other

SATURDAY FOUNDATIONAL GROUP SELECTION SHEET

*Saturday Foundational Social Skills Groups A-D *

$250 for 7-week course

A.) **"LISTEN UP!"**: ***ages 6-8***
B.) **"FAST TRACK TO FRIENDSHIP!"**: ***ages 9-12***
C.) **"UNCERTAIN & ANXIOUS TO CONFIDENT & CALM!"**: ***ages 13-16***
D.) **"ADULTING 101": ages 17+**

Please put a checkmark next to the group you are signing your child up for:

GROUP A:_____10:30 AM-11:30 AM (ages 6-8)

GROUP B:_____12:00 PM-1:00 PM (ages 9-12)

GROUP C:_____1:30 PM-2:30 PM (ages 13-16)

GROUP D:_____3:00 PM-4:00 PM (ages 17+)

Please put a checkmark next to the session you are signing your child up for:

Spring Session: _____Saturday April 4th, 2020- Saturday May 16th, 2020

Summer Session: _____Saturday June 27th, 2020 (skip July 4th)- Saturday August 15th, 2020

Fall Session: _____Saturday September 19th, 2020 (skip October 31st)-November 7th, 2020

Please note that this is your preferred time, not a guarantee, as your child's group time will be determined by their appropriate age group and which social skills they need to improve upon, based upon assessment during the first group session*

You will be contacted once your child has been matched with a group and we have received your sign-up packet. Payment can be collected then over the phone, in the office, or on the first day of classes. The deadline for turning in this packet is 1 week prior to the social skills group beginning.

SPECIALTY SOCIAL SKILL GROUP SELECTION SHEET

PARENT TRAINING GROUPS AND PEER GROUPS FOR CHILDREN& TEENS WITH OPPPOSITIONAL & DEFIANT BEHAVIORS

$600 for 10 WEEK COURSE FOR PARENT&KID SESSION

No child may be signed up without an adult enrolled in the parent training session

-Saturday Morning Group 9AM-10AM for ages 4-12

-Saturday Afternoon Group 4:30 PM-5:30 PM for ages 13+

Please put a checkmark next to the group your family is signing up for:

ODD Saturday Morning Group: 9 AM-10 AM (ages 4-12)_____

ODD Saturday Afternoon Group: 4:30 PM-5:30 PM (ages 13+)_____

Please put a checkmark next to the session you are signing your child up for:

Spring Session: _____Saturday April 4th, 2020- Saturday June 6th, 2020

Summer Session: _____Saturday June 27th, 2020 (skip July 4th)- Saturday August 29th, 2020

Fall Session: _____Saturday September 19th, 2020 (skip October 31st)-November 21st, 2020

Please note that this is your preferred time, not a guarantee, as your child's group time will be determined by their appropriate age group and which social skills they need to improve upon, based upon assessment during the first group session*

You will be contacted once your child has been matched with a group and we have received your sign-up packet. Payment can be collected then over the phone, in the office, or on the first day of classes. The deadline for turning in this packet is 1 week prior to the social skills group beginning.

Parental Consent

I, _____, hereby give permission for *Mind and*

Motion to provide therapeutic services to _____.
Child's Name

_____	_____	_____
Signature (Parent/Legal Guardian)	Relationship	Date

PATIENT CONFIDENTIALITY RIGHTS

We at Mind and Motion, LLC care about protecting your privacy. Evaluation findings and/or information attained through the therapy/consult session is kept strictly confidential and may not be divulged to any other parties with the exception of the following:

The law (Health Insurance Portability & Accountability Act of 1996; HIPAA) requires the following limits of confidentiality in the therapist-patient relationship under the following circumstances (under these provisions, information may be provided to third parties). Please review the attached Georgia Notice for more specific information on your rights as they pertain to HIPAA.

I understand that, under the HIPAA I have certain rights to privacy regarding my healthcare information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly for the purpose of:

a) Suspicion of child abuse or neglect of a minor or elderly person requires mandated reporting to the appropriate protective agencies. Suspicion of any physical or sexual abuse as a victim or perpetrator requires mandated reporting to the appropriate protective agencies.

b) Threats of suicide (risk to self)

c) Threats of Homicidal intentions (risks to others)

d) Court order (privilege held by patient)

e) Consented release of information

I have discussed the above limitations with my evaluator/therapist and understand the limits of confidentiality; I have also reviewed the attached Georgia Notice and understand my rights and limitations as they pertain to HIPAA;

Patient or Parent/Guardian Initials:_____

ACKNOWLEDGEMENT OF RISK FOR THERAPEUTIC EQUIPMENT

I acknowledge there is some risk inherent in the use of the therapeutic equipment at this location/clinic. I agree to indemnify and hold Mind and Motion, LLC from all losses and claims for any injuries or other damage occurring to myself or my child or our belongings from the use of therapeutic equipment. This also applies to any therapeutic activities that my child or I might participate in with therapists outside the building.

Patient or Parent/Guardian Initials:_____

PATIENT DROP-OFF & PICK-UP POLICY

Due to the nature of the many liabilities associated with parking lot traffic, Mind and Motion expects all patients under the age of 15 to be accompanied to and from the office waiting room by patient's legal guardians or caregivers during appointment drop-off and pick-up times. Failure to abide by this policy will result in immediate therapeutic termination.

Patient or Parent/Guardian Initials:_____

CONSENT FOR AUDIO/VISUAL SURVEILLANCE

Mind and Motion, LLC may record and monitor testing or therapy behaviors by supervisory staff by the use of cameras and audio equipment in treatment rooms. The purpose of this monitoring is for our senior staff to unobtrusively monitor behaviors to assess the quality of our test data and provision of certain therapeutic services. This notice is to provide you of our intent and obtain your permission to use this method of quality assurance in our practice. We do not share recordings with any person, party, or group unaffiliated or employed with Mind and Motion, LLC without written consent or unless required by law.
Signing this consent form demonstrates your recognition and acceptance of this technique in providing services to you or your family member.

Patient or Parent/Guardian Initials:_____

CONSENT FOR INTERN / STUDENT PARTICIPATION

Mind and Motion is involved in educational programs to allow students and interns to gain hands on experience in their clinical field of interest. While students and interns may assist in only certain procedures and therapies, they are working under the close supervision of their designated site supervisor. Interns and students are trained and held to the same HIPAA standards and laws. Interns and students are not involved in any clinical or treatment decisions and will not be involved in a capacity that would impede therapeutic progress.

I consent for intern / student participation:

Patient or Parent/Guardian Initials:_____

PATIENT AND CLIENT SATISFACTION ACKNOWLEDGEMENT

In order to help improve both patient/client and the clinicians experience at Mind and Motion, LLC we welcome suggestions to help us improve our customer service. Suggestions can be made directly to our administrative or clinical directors via email. Contact information can be found on staff business cards in our waiting room.

Patient or Parent/Guardian Initials:_____

I have carefully read, clearly understood, and accepted the terms and conditions of Mind and Motion, LLC Company Policies, Notifications, Informed Consents, and Rights stated herein. I acknowledge that this agreement shall be effective and binding upon me, my heirs, assigns, personal representative, and estate and for all members of my family, including minor children.

Patient's Name (please print): _____

_____ _____

Signature (Guardian Signature if Patient is under 18) Date

Billing Agreement

You will be contacted once your child has been matched with a group and that is when payment can be collected. The deadline for turning in this packet is one week prior to the social skills group beginning. Payment can be collected prior to the start date or on the day classes begin. If payment for the group is not received by or on the starting date of the class, the child will not be able to participate.

This agreement will serve as notification that payment for all social skills groups will be due on or before your group's starting date. You will receive a receipt of payment for your records. Payment can be made via cash, check or major credit card over the phone or at the front office. There will be a $25 charge for any check returned to us due to insufficient funds.

_____ _____

Child's Name Signature (Parent/Legal Guardian)

_____ _____

Relationship Date

If all terms of this Billing Agreement are agreeable and acceptable, please sign below. By signing, you are hereby consenting to treatment and acceptance of policies outlined above.

Please select method of payment (all payments non-refundable):

Cash_____ Check (in office) _____
Credit Card (over the phone or in office) _____

Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration to Mind and Motion, LLC. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse settings and media within an unrestricted geographic area.

Photographic, audio or video recordings may be used but is **not limited** to the following purposes:

-conference presentations

-educational presentations or courses

-informational presentations

-on-line educational courses

-educational videos

-company marketing and promotional purposes

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the Mind and Motion, LLC 2020.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for marketing or educational purposes.

Full Name_____

Street Address/P.O. Box_____

City _____

Prov/Postal Code/Zip Code_____

Phone _____ Fax _____
Email Address_____

Signature_____ Date_____

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature_____ Date_____

Additional Information:

- Your child should be able to use the restroom independently, eat independently, follow simple instructions with minimum cues, and attend to tasks for 10 or more minutes with minimum cues.

- Children will be assigned to groups based on their chronological age however, group assignments will also be based on each child's developmental level in order to maximize overall therapeutic outcome.

- We accept check, cash, and debit/credit cards as payment. No refunds are given. Our staffing, supplies and activities are based on the number of patients signed up by the deadline. We apologize in advance for any inconveniences that might cause