Behavior Analysis Consultants of Mid Florida
304 E Pine St. #19
Lakeland, FL 33801

Phone: 863-614-0048
Fax: 863-279-1204
www.bacmf.com

REFERRAL FORM

Demographic Information

Child's Name: _____ DOB: _____ Gender: _____

Primary Caregiver(s) Name: _____

Address: _____ City/Zip:_____

Email: _____Phone #: _____ Phone #:_____

School: _____ Exceptional Student Education Y__ N__ 504 Plan Y___ N___

Teacher: _____ Tel#: _____ Daycare:_____

Referral Information

Referring Physician/Person referring client for services: _____

Diagnosis (include diagnosis documentation): _____

Reason for Referral: _____

_____

_____

Is client verbal? If so, describe his or her skills:_____

_____

_____

Preferred Days and Times

_____

_____

Other specific needs, medical diagnoses or information we should be aware of:_____

_____

_____

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PRE-AUTHORIZATION AND/OR PAYMENT INFORMATION

Choose one of the following:

For Medicaid Clients:

Note: Medicaid covers behavior analysis services if the following applies to you
1. Client is 21 years of age or younger
2. Client is diagnosed with a developmental disability (e.g., Autism), cognitive impairment (Down syndrome), mental health disorder, behavioral disorder (e.g., ADHD or Oppositional defiant disorder) or other behavioral or learning disorder

Patient Medicaid #:_____

*****Medicaid clients MUST submit documentation stating your child's diagnosis and recommending Applied Behavior Analysis (ABA) in order to obtain pre-authorization for services. Documentation must include date of birth, date of referral, diagnosis, reason for referral (i.e., to address behavioral needs), and a signature by a licensed doctor. For school services a copy of the most recent IEP is required.**

For Private Insurance Clients:

Note: Every individual's insurance is different and exclusions may vary, however, generally private insurance will cover ABA services if the following applies to you
1. Client is 18 years of age or younger OR in high school
2. Insurance policy is a group policy (Please check with employer or insurance company regarding this)
3. Policy was written in the state of Florida
4. Client is diagnosed with developmental disability (e.g., Autism, pervasive developmental disorder)

Policy Holder's Name: _____DOB:_____ Insurance Company: _____

Provider Phone #: _____Policy #: _____ Group #: _____ Member ID #:_____

*****Insurance clients MUST submit documentation stating your child's diagnosis (include evaluations) and recommending Applied Behavior Analysis (ABA) in order to obtain pre-authorization for services. Documentation must include date of birth, date of referral, diagnosis, reason for referral (i.e., to address behavioral needs), and a signature from a licensed doctor. For school services a copy of the most recent IEP is required.**

For Medwaiver Clients:

Medicaid #: _____ Support Coordinator Name/Agency: _____

Support Coordinator Name:_____ Phone: _____ Email: _____

Address: _____ City/Zip: _____

Support Plan Begin Date: _____ End Date: _____

Previous Provider of ABA (if applicable): _____ Phone/Email:_____

For private pay Clients:

Please complete page 4. We accept cash or check.

Please send referral and consent form along with any supplemental documentation in 1 of the following ways:

****FAX:** Attention: Ashley Miller at 863-279-1204******SCAN & EMAIL:**amiller@bacmf.com**
_____ ****MAIL:**BACMF304 E Pine St. #19, Lakeland, FL 33801**

*****DO NOT FORGET TO SUBMIT DIAGNOSIS OR IEP DOCUMENTATION WITH YOUR COMPLETED REFERRAL*****

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CONSENT TO BILL INSURANCE

If you are using your insurance/Medicaid for payment, complete this form. Otherwise skip.

Agreement made on _____, _____, between _____,

referred to herein as *Policyholder*, and Behavior Analysis Consultants of Mid Florida, a limited liability corporation organized and existing under the laws of the state of Florida, with its principal office located at 304 E Pine St. #19 Lakeland, FL 33801, referred to herein as *Agency*.

My signature below indicates that:

- I give permission for *agency* to bill my insurance company for covered services; and to exchange information necessary to secure payment for these services. Such necessary information may include my child's diagnosis, service dates, types of services and other information related to services necessary to process claims.

  _____ *(Policyholder Initials)*

- I will notify *agency* of any changes to my child's health insurance coverage, as well as any denial information.

  _____ *(Policyholder Initials)*

- I understand that it is my responsibility to know the parameters of my insurance policy, including copay or coinsurance amounts, and that any estimates of payment by my insurance company are not a guarantee or proof of payment. I am aware that the private pay rate for services is $65 per hour and thatI am responsible for any balance that my insurance company does not authorize for payment.

  _____ *(Policyholder Initials*

_____ _____
Policyholder Signature (adult caregiver) Date

_____ _____
Agency Representative Signature Date

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AGREEMENT FOR APPLIED BEHAVIOR ANALYSIS SERVICES

If you are paying privately, complete this form. Otherwise skip.

Agreement made on _____, _____, between _____ of _____, referred to herein as *Client*, and Behavior Analysis Consultants of Mid Florida, a limited liability corporation organized and existing under the laws of the state of Florida, with its principal office located at 304 E Pine St. #19 Lakeland, FL 33801, referred to herein as *Agency*.

1. **Behavior Analysis Services and Rates**
   Agency agrees to furnish Client with the services of a Board Certified Behavior Analyst (BCBA or BCaBA) at the rate of $65.00 per hour.

2. **Monthly Invoicing**
   Agency will invoice Client on a monthly basis and Client agrees to pay entire invoice within 30 days of receipt. Invoices can be paid by check only and should be addressed to Behavior Analysis Consultants of Mid Florida at 304 E Pine St. #19 Lakeland, FL 33801. Please contact 863-614-0048 for any billing questions or concerns or ask your behavior analyst.

3. **Invoicing Standard**
   Clients can expect to be invoiced according to the amount of time the Agency spends performing the service. For example, if a Client and the Agency agree to weekly one-hour visits, the Client would expect to be invoiced for 4 hours each month at a rate of $65.00 per hour. In addition, a one-time behavioral assessment fee of $150.00 will invoiced upon completion of the assessment. This fee will usually appear on the first or second monthly invoice. With the exception of the assessment fee, Clients can expect to be invoiced for face-to-face contact only.

4. **Unpaid Invoice Policy**
   Client agrees that services will be suspended if an invoice remains unpaid for 30 days from the invoice date. The behavior analyst will review all appropriate therapeutic recommendations with Client should services be suspended due to non-payment. Client agrees that once an outstanding balance is paid, services may resume at the discretion of the Agency. In addition, in an effort to protect our consumers, the Agency reserves the right to request immediate payment or partial payment (at least 50% of total invoice), before services continue, when a Client's balance has exceeded $500.00. This applies even if the balance is not yet overdue.

5. **Voluntary Participation**
   Client and Agency agree that this agreement may be forfeited at any time by either party upon notification.

_____ _____
Client Signature (adult caregiver) Date

_____ _____ _____
Agency Representative Signature Title Date

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CONSENT FOR ASSESSMENT, TREATMENT AND CONSULTATION

Initial Box(es) as appropriate:

☐ I give my consent for assessment, treatment, and/or consultation to be provided for _____ (your name) and _____ (child's name).

☐ Assessment procedures may include

Review of documentation, records, and/or referral information

Interviews/questionnaires with parents, children, and/or significant others

Direct observation/influence of behaviors in natural settings

☐ Treatment and/or Consultation may include:

Caregiver training in published curricula or individualized strategies

Implementation of behavior intervention plans and/or general recommendations to improve child behavior

In-home observation and support for appropriate caregiver application of behavior intervention plans

Role-modeling appropriate application of parenting tools during interactions with client

Collaboration with the provider of child welfare services, other service providers, and community entities.

I authorize the Behavior Analysis Consultants of Mid Florida, LLC., and its employees to release to the REFERRING AGENCY any and all information BEHAVIOR ANALYSTS have gathered or acquired or which I have provided to BEHAVIOR ANALYSTS, including, but not limited to any medical, psychological, educational or behavioral information related to myself or my child, from the following persons or agencies:

_____
Primary Care Physician or Referring MD

_____
School, administrator, counselor or teacher

☐ I decline to release my health information at this time

_____
Specialist or other provider

_____ _____
Client Signature (if client is an adult) Date

_____ _____
Parent / Guardian / Legal Custodian Signature (if client is a child) Date

_____ _____
Agency Representative (if applicable) Date

_____ _____
Agency Name (if applicable) Email or phone number