NEW PATIENT CONSENT FOR APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES:

Thank you for choosing Balance ABA. We understand that navigating an autism diagnosis can feel overwhelming, but you're not alone—we're here to support you every step of the way. The information you provide in this questionnaire will help us begin services ensure your coverage for ABA therapy is in place.

At **Balance ABA**, our Board Certified Behavior Analysts (BCBA) offer individualized ABA services for children with a diagnosis of Autism Spectrum Disorder. Treatment can be provided in the home, school, and community settings based on your child's needs and the behavior analyst's recommendations. Treatment tailored to unique needs and guided by thoughtful clinical recommendations is our top priority. Our interventions aim not only to support meaningful behavioral growth, but also to enhance the overall quality of life for both children and their families.

We believe that families are essential partners in the therapeutic process. Active parent involvement plays a powerful role in strengthening outcomes by promoting consistency, reinforcing skills, and extending progress beyond formal sessions. That's why your BCBA will also collaborate with you to set meaningful goals, ensuring that family support is woven into every step of the treatment journey.

We offer a variety of ABA-based therapies tailored to meet each child's unique needs. These may include Discrete Trial Training (DTT), Analysis of Verbal Behavior (AVB), Natural Environment Training (NET), Functional Behavior Assessments (FBA), and Social Skills Training. Your child's treatment plan will be thoughtfully developed in collaboration with your BCBA to ensure the most effective approach.

Therapy is typically scheduled 1 to 5 times per week, with sessions ranging from 2 to 8 hours depending on your child's goals and availability. Most children benefit from 20 to 40 hours of therapy per week to achieve meaningful progress. In some cases, sessions may be scheduled during school hours, and we're happy to work with school administrators to coordinate services that support your child's development across environments. Some children also benefit from treatment in the community which can be provided on a cases by cases basis.

New Patient Insurance Eligibility Check Form

Section 1: Client Information

Child's Full Legal Name (First, Middle, Last):			
Date of Birth	_____ MM/DD/YYYY	Gender (Optional): circle	Male / Female / Other Prefer not to say
Parent/Guardian Name		Relationship to Client	
Phone Number		Email Address	
Parent/Guardian Name		Relationship to Client	
Phone Number		Email Address	
Emergency contact name:		Emergency contact phone number:	

Preferred Contact Method: Phone / Email / Text

Section 2: Address

Street Address:		
City:	State:	ZIP Code:

Section 3: Insurance Details

Insurance Provider		Insurance Phone *(from back of card):*	
Member ID #:		Group ID #:	
Policyholder's Full Name			
Policyholder's DOB		Policyholder's Relationship to Client	

Do you have any secondary insurance including the Katie Beckett waiver, Deeming Waiver, and/or Medicaid?

**Please note per the GA Medicaid ASD manual: 801. Prior Approval for Adaptive Behavior Services (ABS) Prior Authorization (PA) is required for all Medicaid-covered ABS. Services without a PA will not be covered. A documented diagnosis of ASD must be established by a licensed physician or psychologist, or other licensed professional as designated by the Medical Composite Board prior to completing a PA for Behavioral Assessment or Treatment Services. As stated in 701, the diagnostic evaluation must use valid and reliable evaluation tools that conform to industry standards and include direct observation, parent/caregiver interviews, and standardized tools for the diagnosis of autism.*

Section 4: Diagnostic Information

Diagnosis (if known):		Referring Physician:	
Level:		Currently Receiving ABA Services Elsewhere?	Yes / No

Section 5: Please tell us about your child:

What are your expectations for treatment?
What are your primary concerns?
Has your child ever received a psychological exam?
Has your child received ABA services before? Y/ N If so when? _____ Which Company: _____
Is your child currently in School? If so, has an Individualized Education Plan (IEP) been provided to you? Y/N

School schedule (if applicable):

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Availability for ABA:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Additional Comments

Consent Section

I _____(parent name) authorize Balance ABA LLC, to contact my insurance provider to verify benefits for ABA services. I understand that verification of benefits does not guarantee payment and that I will be notified of my coverage details.

☐ I Agree

Child's name: _____

Parent/Legar Guardian name:_____

Signature: _____**Date:** _____

Please be sure to attach the following documents:

- A copy of your insurance card front and back.
- The referral letter for ABA and referring physician contact information.
- The diagnostic report confirming ASD 299.00 (F84.0)
- IEP- for GA Medicaid patients
- (OPTIONAL) Submit any other reports such as SLP, OT or from other ABA providers