

CLIENT INTAKE PACKET

Carolina Behavioral Innovations, LLC

Please complete all sections of this packet.

This packet collects the information required to begin services. Sections marked with consent or signature lines must be reviewed and signed by a parent or legal guardian. Supporting documents (medical diagnosis, prior evaluations, referrals, and insurance card copies) should be emailed to admin@cbiaba.com.

CHILD INFORMATION

Child's Full Name	
Child's Date of Birth	

Gender

Male Female

Please email admin@cbiaba.com copies of: Medical Diagnosis | Previous Evaluations | Referral (if applicable)

PRIMARY HEALTH INSURANCE INFORMATION

Insurance Card Copies — please email front & back to admin@cbiaba.com

Insurance Company	
Member ID #	
Group #	
Policyholder's Name	

Policyholder Gender

Male Female

Policyholder Date of Birth	
Policyholder SSN	
Street Address	
Address Line 2	
City	
State	
ZIP	

SECONDARY HEALTH INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company	
Member ID #	
Group #	

SECONDARY HEALTH INSURANCE INFORMATION (IF APPLICABLE) (CONT.)

Policyholder's Name	
Policyholder Gender	
Male	Female
Policyholder Date of Birth	
Policyholder SSN	
Street Address	
Address Line 2	
City	
State	
ZIP	

PARENT / GUARDIAN INFORMATION

Custodial Parent Status

Both Parents Married

Child Lives with Father

Child Lives with Mother

Custodial Parent Name	
Email Address	
Phone Number	
Occupation	
Parent #2 Occupation	

EMERGENCY CONTACT

Other than Parent / Guardian

Emergency Contact Name	
Emergency Contact Phone	

DESIRED SERVICES

ABA Therapy (select all that apply)

In-Center ABA In-Home ABA In-School Shadowing ABA

Speech Therapy

Yes No

Occupational Therapy

Yes No

HIPAA AGREEMENT FORM

Privacy Policy

Carolina Behavioral Innovations is dedicated to maintaining the privacy of your protected health information (PHI). PHI will only be used appropriately for treatment, payment, healthcare operations, or when required by law.

Carolina Behavioral Innovations:

- Will not sell PHI
- Will not use PHI for marketing or fundraising
- Will only disclose PHI to legal guardians unless written authorization is provided

Your Rights

You have the right to:

- Access your records
- Know who accessed your PHI within the last 6 years
- Limit access to your records
- Revoke previously granted authorization
- Receive notice of unauthorized access
- File complaints with the U.S. Department of Health and Human Services

I have read and understood the Privacy Policy above.

Printed Name	
Date	

Signature

Date

PAYMENT AGREEMENT

Child's Name	
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I authorize Carolina Behavioral Innovations to submit insurance claims for services provided to my child.

I Understand:

- Insurance authorization does not guarantee payment
- I am financially responsible for all unpaid balances
- Copays, deductibles, and coinsurance are required by law

- Balances are billed monthly and due within 15 days
- Services may be terminated for balances unpaid over 90 days

Additional Fees May Include:

- Field trip or camp fees
- Replacement costs for damaged electronics
- Collection costs and attorney fees

Invoice Disputes

Invoice disputes must be submitted within 90 days of invoice receipt.

Parent Name	
Parent Date of Birth	
Date	

Signature _____

Date _____

HEALTH INFORMATION DISCLOSURE

Child's Name	
Child's Date of Birth	
Doctor's Name	
Doctor's Fax	
Authorization Start Date	
Authorization Expiration	

I authorize Carolina Behavioral Innovations to receive and share health information as necessary for treatment and coordination of care.

Date	
Parent Name	

Parent Signature _____

Date _____

PARENT HANDBOOK AGREEMENT

Child's Name	
Parent Name	

Parent Handbook URL: _____

PARENT HANDBOOK AGREEMENT (CONT.)

I have read and agree to the Parent Handbook.

Date	
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Parent Signature

Date

AUTHORIZATION FOR PICK-UP

Child's Name	
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Child's Date of Birth	
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Custodial Parent Name	
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Authorized Pick-Up Individuals

Name	Phone Number

I understand my child will only be released to authorized individuals listed above.

Date	
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Custodial Parent Signature

Date

Parent #2 Signature

Date

TRAUMA SCREENING

Child's Name	
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Child's Date of Birth	
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Mark YES if it happened to your child, to the best of your knowledge.

Question	Yes	No
Serious natural disaster (flood, tornado, hurricane, earthquake, fire)		

Question	Yes	No
Serious accident or injury (car/bike crash, dog bite, sports injury)		
Threatened or hurt within the family		
Threatened or hurt in school / the community		
Experienced bullying in person		
Experienced bullying online		
Stressful or scary medical procedure		
Foster care history		
Adoption history		
Parents separated / divorced during the child's life		

EMAIL & TEXT MESSAGE CONSENT

Consumer Name	
Preferred Phone Number	

I consent to communication via email and/or text messaging.

Consumer / Guardian Signature

Date

BCABA CASE MANAGEMENT CONSENT

I understand that a BCaBA may provide or manage ABA services under BCBA supervision.

I consent to services under this supervision model.

Consumer / Guardian Signature

Date

INFORMED CONSENT, TELEHEALTH CONSENT, VIDEO SURVEILLANCE CONSENT, & RELEASE OF LIABILITY

The following pages form one combined consent and release document. Please review each part and sign where indicated.

Child's Name	
Parent / Guardian Name	
Date	

INFORMED CONSENT & VOLUNTARY ENROLLMENT

I hereby voluntarily apply for and consent to the provision of behavioral health and related services by Carolina Behavioral Innovations ("CBI"), including services provided by its employees, contractors, and supervised clinical staff. This consent applies to myself and the child identified above and includes all services deemed clinically appropriate by CBI in accordance with applicable laws, professional standards, and the child's individualized treatment plan.

Guardian Participation & Training Requirements

I understand and acknowledge that parent and/or guardian involvement is an important component of my child's treatment.

I agree to participate in required caregiver training meetings, treatment planning sessions, and progress reviews.

CBI strongly encourages the participation of all parents or legal guardians, when applicable, to support consistency and positive treatment outcomes.

Failure to participate in required parent involvement activities may impact the child's progress and may result in modification or discontinuation of services.

Attendance Requirements

I understand that regular and consistent attendance is essential to the effectiveness of behavioral services.

I agree that my child is expected to maintain a minimum attendance rate of 90% of scheduled sessions each month and throughout the duration of enrollment.

I acknowledge that chronic absenteeism, excessive tardiness, or failure to meet attendance requirements may result in:

- Reduced services
- Modification of scheduling
- Suspension or termination of services
- Applicable cancellation or no-show fees

Video, Audio, & Monitoring Consent

I acknowledge and agree that, for safety, supervision, quality assurance, and transparency purposes, video and/or audio monitoring may occur throughout the clinic, excluding restrooms.

Images and audio of my child may be captured during services.

Live video feeds may be displayed in designated parent viewing areas. I understand and accept that other parents, guardians, clients, or authorized visitors may see or hear my child on these viewing monitors.

I acknowledge that such monitoring is not used for marketing or public distribution and is maintained in accordance with applicable privacy laws and CBI policies.

Guardian Rights

I understand that I may request a referral to another provider if I am dissatisfied with services or progress.

I understand that I have the right to:

- Refuse services
- Withdraw consent for services at any time
- Request records in accordance with applicable law
- Ask questions regarding treatment recommendations

I further acknowledge that continued participation in services constitutes ongoing voluntary informed consent.

CBI Rights to Refuse or Discontinue Services

I understand and agree that Carolina Behavioral Innovations reserves the right to refuse, limit, modify, or discontinue services at any time, including but not limited to circumstances involving:

- Noncompliance with clinic policies
- Safety concerns
- Attendance or participation issues
- Nonpayment or insurance issues
- Clinical determination that services are no longer appropriate

Such decisions will be made in accordance with applicable laws, ethical standards, and clinical judgment.

Parent / Guardian Signature

Date

TELEHEALTH CONSENT

Telehealth Services

I understand that Carolina Behavioral Innovations ("CBI") may provide behavioral health services using telehealth or telemedicine, which involves the delivery of healthcare services through two-way interactive audio and/or video communication and electronic transmission of clinical information.

Telehealth services may include, but are not limited to:

- Clinical consultations
- Assessments and evaluations
- Parent training and caregiver meetings
- Treatment planning
- Supervision and follow-up services

I understand that the healthcare provider or specialist may be located at a different physical location than myself and/or my child.

Limitations of Telehealth

I acknowledge and understand that:

- Telehealth services differ from in-person services
- Certain aspects of care may be limited by technology, including video quality, audio clarity, internet connectivity, or the inability to perform physical interventions
- Telehealth may not be appropriate for all clinical situations
- CBI may determine that in-person services or referrals are necessary
- Telehealth involves electronic transmission of information, which may carry risks including interruptions or technical failures

Privacy During Telehealth

I understand that:

- I will be informed if additional personnel are present during a telehealth session
- I may grant or deny consent for additional personnel participation
- I may request that non-essential personnel leave the session
- I may request a private consultation with the provider when clinically appropriate

I acknowledge that participation in telehealth may increase the risk of privacy or security breaches and accept these risks.

Recording & Documentation

Telehealth sessions may be recorded when clinically or operationally necessary.

Video, audio, images, documents, and other data may be created or transmitted during telehealth services and may become part of the medical record.

De-identified recordings or data may be used for training, quality assurance, administrative, technical, or research purposes as permitted by law.

CBI will maintain telehealth records in accordance with HIPAA and applicable privacy laws.

Voluntary Consent

My participation in telehealth is voluntary, and I voluntarily consent to the use of telehealth services as described above.

I understand that I have the right to:

- Refuse telehealth services
- Withdraw consent at any time
- Stop participation in a telehealth session without penalty
- Request an in-person appointment when available and clinically appropriate

Parent / Guardian Signature

Date

VIDEO SURVEILLANCE & AUDIO RECORDING CONSENT

Surveillance Notice

I acknowledge and understand that Carolina Behavioral Innovations ("CBI") may utilize video and audio surveillance throughout its centers for purposes including:

- Safety
- Supervision
- Quality assurance
- Operational oversight
- Incident review

Restrooms are excluded from surveillance.

Recorded footage may be stored on secure, password-protected systems and retained for a limited period before being overwritten unless preservation is required for legal, safety, or compliance purposes.

Permitted Use of Recordings

I understand and agree that recordings may be used for marketing, advertising, or public dissemination.

Recordings may be reviewed internally for:

- Employee training
- Parent or caregiver training
- Quality assurance
- Incident review
- Compliance and risk management

All use will be conducted in accordance with HIPAA and applicable privacy laws.

Consent to Capture & Store Recordings

I grant Carolina Behavioral Innovations permission to capture, record, store, and maintain video and audio recordings of my child while present in the CBI facility.

I understand that CBI maintains ownership and control of recordings created within the facility for lawful operational, safety, and compliance purposes.

I waive any right to inspect, approve, or control the use of such recordings as permitted herein.

Prohibition on Parent Recording

I understand and agree that parents, guardians, and visitors are prohibited from taking photographs, videos, or audio recordings inside the CBI facility without written authorization.

No individual may possess or obtain copies of CBI surveillance recordings except as required by court order or legal mandate.

Confidentiality Obligations

I acknowledge that while present in the CBI centers, I may see or hear information relating to other clients.

I agree that any such information is confidential and will not be shared, recorded, discussed, or disseminated in any manner.

Release of Liability

I release and hold harmless Carolina Behavioral Innovations, its owners, officers, directors, employees, contractors, and agents from claims arising out of the lawful capture, storage, review, or internal use of recordings as permitted herein.

This release includes claims related to:

- Invasion of privacy
- Emotional distress
- Unauthorized use of likeness

This release shall remain binding and enforceable to the fullest extent permitted by law.

Parent / Guardian Signature

Date

RELEASE OF LIABILITY & ASSUMPTION OF RISK

Voluntary Assumption of Risk

This Voluntary Assumption of Risk, Release of Liability, Indemnification, and Hold Harmless Agreement ("Agreement") is entered into by the undersigned parent or legal guardian ("Parent/Guardian"), on behalf of themselves and the minor child identified above ("Child"), including their heirs, representatives, successors, and assigns.

As a condition of receiving behavioral health, therapy, supervision, training, community-based, in-home, or center-based services from Carolina Behavioral Innovations ("CBI"), the Parent/Guardian knowingly and voluntarily agrees as follows:

Acknowledgment of Supervision & Risks

I acknowledge that my child may participate in activities involving movement, play, physical interaction, emotional responses, and behavioral interventions.

I understand that despite reasonable supervision and safety procedures, injuries, accidents, or unforeseen events may occur.

Risks may include, but are not limited to:

- Slips or falls
- Collisions or behavioral incidents
- Playground activity
- Use of therapy equipment
- Interaction with other clients
- Community-based activities
- Physical behaviors associated with behavioral treatment

I knowingly and voluntarily assume all risks, both known and unknown, foreseeable and unforeseeable, arising out of or related to participation in services.

I specifically authorize my child to participate in age-appropriate supervised activities, including playground equipment, climbing equipment, trampolines, sensory equipment, and community activities when supervised by CBI staff.

I understand that such activities carry inherent risks, including the possibility of serious injury or death, which cannot be entirely eliminated.

Personal Property

I understand that clients may bring personal items into the clinic or home sessions at their own risk, including:

- Tablets or communication devices
- Electronics
- Toys
- Blankets
- Specialized equipment

CBI is not responsible for loss, theft, or damage to personal property.

Release of Liability

To the fullest extent permitted by applicable law, I release, waive, discharge, and hold harmless Carolina Behavioral Innovations, including its owners, officers, employees, contractors, and agents, from any claims, demands, damages, losses, liabilities, costs, or expenses arising out of or related to:

- Participation in services
- Presence at a CBI facility
- Community-based or off-site activities
- Use of equipment or playground structures
- Supervision or care provided by staff
- Ordinary negligence where permitted by law

This release does not apply to gross negligence or willful misconduct where prohibited by law.

Indemnification

I agree to defend, indemnify, and hold harmless Carolina Behavioral Innovations from claims, damages, liabilities, costs, and attorney's fees arising out of:

- My child's actions or behaviors
- Damage caused by my child to persons or property

- Claims brought by third parties related to my child's participation in services

Severability

If any portion of this Agreement is found unenforceable, the remaining provisions shall remain valid, binding, and enforceable to the fullest extent permitted by law.

Parent / Guardian Signature

Date

OFFICE USE ONLY

Date Intake Received	
Staff Initials	
Start Date	

Insurance Verified

Authorization Requested

Please return completed intake packets and supporting documents to: admin@cbiaba.com