Universal Behavioral Health

2715 E Russell Rd. Las Vegas NV 89120

P: 725-238-4115

F: 725-238-4116

CLIENT INFORMATION

CHILDS FULL NAME:	
DATE OF BIRTH:	
INSURANCE ID #	
CHILDS GENDER:	
CURRENT ADDRESS:	

PARENT/LEGAL GUARDIAN

FULL NAME:	
DATE OF BIRTH:	
OCCUPATION:	
PLACE OF EMPLOY-MENT:	
WORK PHONE NUM-BER:	
CELL PHONE NUM-BER:	
EMAIL ADDRESS:	
RELATIONSHIP TO CHILD:	

HOME ENVIRONMENT

CHILD LIVES IN:	**FAMILY HOME** ☐ **GROUP HOME** ☐ **FOSTER HOME** ☐ **OTHER** _____			
CHILD LIVES WITH:	BIOLOGICAL MOTHER	☐	BIOLOGICAL FATHER	☐
	ADOPTIVE MOTHER	☐	ADOPTIVE FATHER	☐
	FOSTER MOTHER	☐	FOSTER FATHER	☐
	STEP MOTHER	☐	STEP FATHER	☐

SIBLINGS/HOUSEHOLD MEMBERS OTHER THAN PARENT/GUARDIAN

NAME:	
AGE:	
RELATIONSHIP:	
NAME:	
AGE:	
RELATIONSHIP:	
NAME:	
AGE:	
RELATIONSHIP:	
NAME:	
AGE:	
RELATIONSHIP:	

***PLEASE LIST ALL PAST AND CURRENT THERAPIES YOUR CHILD HAS RECEIVED BY COMPLETING THE BOXES BELOW**

SERVICE	START/ END DATE (MONTH / YEAR)	HOW OF-TEN? (NUMBER OF TIMES PER WEEK)	LENGTH OF SESSIONS? (MINUTES)	MAIN TARGETED GOALS	EFFECT OF THERAPY? (WORSE, NO CHANGE,	CONTACT INFO
OCCUPATIONAL THERAPY						
PHYSICAL THERAPY						
SPEECH THERAPY						
EARLY INTERVENTION						
ABA THERAPY						
OTHER						

PREFERRED SCHEDULE

Please share your child's availability for services between the hours of **8:30am-6:00pm.** We will try our best to accommodate preferred schedules, however some adjustments may need to be made to ensure appropriate staffing.

ABA therapy requires 15-30 hours per week based on clinical recommendation 5 days a week at the same time each day.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

I verify that the above schedule was completed by me, _____ (full name) and that I will not change my child's availability until my child's authorization is up for renew- al. I understand that changing my child's availability may impact UNVBH's ability to deliver services.

_____

Parent Signature

Authorized Pick-Up List

The people listed below have my authorization to pick up my child from the clinic. I will inform the Director, each time a special pick-up is necessary via email.

I understand that my child will only be released to individuals listed below, if I am unavailable. I also realize that they will be required to provide proper identification each time that they arrive at the clinic. If an individual is not listed on this form, a telephone call WILL NOT be sufficient to release the child to that individual.

Parent/Guardian Signature _____

Child's Name

_____

NAME	RELATIONSHIP	PHONE

These people are NOT allowed to pick up my child. **PLEASE NOTE**: A copy of the court decision for custody cases MUST be on file in order for the program NOT to release a child to his/her non-custodial parent.

NAME	RELATIONSHIP	PHONE

Video Surveillance Policy

To ensure the safety and security of all children, staff and parents as well as the security of our ABA clinic, Universal Behavioral Health is equipped with a 24-hour video surveillance system. Security cameras have been installed in our classrooms, hallways, indoor play area and parking lot. We may conduct video surveillance of any portion of our premises at any time, the only exception being private areas of restrooms.

Our video/security cameras have been positioned in appropriate places within and around our clinic facility and are used to help promote the safety and security of people and property. The following are just some of the many benefits of having security cameras installed in the clinic:

- Security cameras keep children and staff safe.
- Owners/Executive Directors can better monitor the entire facility and supervise/observe staff's interactions with children and other staff members effectively.
- Our cameras help provide peace of mind to our parents and staff members.

Because we respect the privacy of all children, parents and staff in our clinic, our 24-hour video surveillance system/security cameras are for internal purposes only.

ONLY the Clinical Director or Behavior Analysts are allowed to view our security cameras/ video footage either at the clinic office at the site OR via live video footage when the Clinical Director is not on site.

By signing below, I am indicating I have read, understand, and agree to comply with the video surveillance policy.

Signature: _____

Date:_____