CHILD'S INFO	
Child's Name:	
Child's Date of Birth:	
Child's Gender:	☐ Male ☐ Female

PRIMARY HEALTH INSURANCE INFO	
Insurance Company:	
Member ID:	
Group#	
Policyholder's Name:	
Policyholder's Birthday:	
Policyholder's Social Security:	
Policyholder's Address:	
Policyholder's Gender:	☐ Male ☐ Female

SECONDARY HEALTH INSURANCE INFO	
Insurance Company:	
Member ID:	
Group#	
Policyholder's Name:	
Policyholder's Birthday:	
Policyholder's Social Security:	
Policyholder's Address:	
Policyholder's Gender:	☐ Male ☐ Female

LEGAL GUARDIAN INFO These adults are able to obtain health information about child and pick up the child from SOS	
Household Arrangements:	☐ Parents are married and have equal rights ☐ Parents are divorced, Mom is primary custodian ☐ Parents are divorced, dad is primary custodian ☐ Other
Primary Guardian Name:	
Primary Guardian Email:	
Primary Guardian Phone:	
Guardian #2 Name:	
Guardian #2 Email:	
Guardian #2 Phone:	

EMERGENCY CONTACT These adults will be called in the event of an emergency if guardians can't be reached	
Emergency Contact Name:	
Emergency Contact Phone:	

CHILD'S MEDICAL INFO	
Autism Diagnosis:	☐ No, the child does not yet have an official Autism diagnosis ☐ Yes, Diagnosed by a doctor ☐ The school did an Autism Screening
Allergies:	
Medications:	
History of Seizures:	
Any other medical history:	

DESIRED SERVICES	
ABA Therapy:	☐ In Center ABA Full-time or Part-time options available ☐ In-Home ABA Must live within 10 miles of an SOS center Must have no aggressive behaviors Additional Mileage Fees may apply ☐ School Shadowing ABA Must have school's approval Additional Mileage Fees may apply
Speech Therapy:	☐ I want to use the SOS speech therapist ☐ I want my current speech therapist to go to the SOS center
Occupational Therapy:	☐ I want to use the SOS occupational therapist ☐ I want my current occupational therapist to go to the SOS center
Social Skills Group Classes:	☐ Primary Social Group (Kindergarten - 2nd grade) ☐ Elementary Social Group (3rd - 4th grade) ☐ Intermediate Social Group (5th - 6th grade) ☐ Tween Social Group (7th - 8th grade)
Before/After Care	☐ Early Drop Off (as early as 7:00am) ☐ Late Pick Up (as late as 6:00pm)

PARENT HANDBOOK AGREEMENT

The Success On The Spectrum ("SOS") Parent Handbook, which outlines policies, procedures, expectations, and requirements governing my child's participation in services, is available on our website.

I UNDERSTAND AND AGREE THAT THE PARENT HANDBOOK INCLUDES, but is not limited to, policies regarding:

- Client rights and responsibilities
- Attendance requirements (including the 85% attendance standard)
- Parent/caregiver involvement and required parent training
- Fees, billing, late pickup, no-call/no-show, and financial responsibility
- Health, illness, medication, and emergency procedures
- Safety policies, video/audio surveillance, and parent viewing rooms
- In-center, in-home, in-school, and community-based services
- Authorized pick-up, custody documentation, and release procedures
- Field trips, transportation rules, and off-site activities
- HIPAA privacy, confidentiality, and permitted disclosures
- Behavior expectations, ethics, and grounds for suspension or termination of services

BY SIGNING BELOW, I AGREE THAT:

- The Parent Handbook is incorporated by reference into my enrollment agreement and is binding upon me and my child.
- I agree to comply with all SOS policies, whether written, electronic, or updated, as a condition of continued services.
- I understand that failure to follow SOS policies may result in reduced services, suspension, or termination, at the sole discretion of SOS.
- I acknowledge that SOS may update or modify policies as required by law, accreditation, safety needs, or operational requirements, and that updated policies will apply once provided or posted.
- I understand that SOS locations are independently owned and operated and that policies are enforced consistently to protect clients, staff, and families.
- I understand that continued participation in services constitutes ongoing acceptance of the Parent Handbook and all related agreements.

Guardian Name	Guardian Signature	Date

Wet Signature Required

NOTICE OF PRIVACY PRACTICES

LEGAL GUARDIAN'S RIGHTS

- Receive a copy of this Notice of Privacy Practices
- Access your child's medical records
- Request corrections to inaccurate or incomplete records
- Request restrictions on certain uses or disclosures
- Request confidential communications (e.g., alternate contact method)
- File a complaint to SOS Franchising or HHS without fear of retaliation if you believe your privacy rights have been violated

SOS PRIVACY POLICY

- Success On The Spectrum ("SOS") is committed to protecting the privacy and security of your child's Protected Health Information ("PHI") in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable state laws.
- SOS will not use or disclose your PHI for marketing or fundraising purpose
- SOS will not sell your PHI to anyone for any reason.
- SOS will only use your PHI in an appropriate manner for treatment.
- SOS will only disclose PHI to the child's legal guardian(s)

HOW SOS MAY USE AND DISCLOSE PHI (WITHOUT YOUR WRITTEN AUTHORIZATION)

- To provide, coordinate, or manage your child's care, including communication between therapists, supervisors, clinical directors, and other healthcare providers involved in your child's treatment.
- To bill and receive payment from insurance companies, Medicaid, or other third-party payors, including utilization reviews and audits.
- For clinic operations such as quality assurance, staff training, supervision, accreditation, compliance reviews, audits, licensing, and business management.
- We may disclose PHI without consent when required by law, including but not limited to: Court orders, subpoenas, or legal proceedings, Mandatory reporting of abuse, neglect, or threats of harm, Public health reporting requirements, Law enforcement requests when legally required
- SOS may disclose your PHI without your written permission to company attorneys, accountants, consultants, and others to make sure that SOS is in compliance with applicable laws.
- If necessary to prevent a serious or imminent threat to your child, another person, or the public or in the event of an emergency situation (such as a hospital visit).

VIDEO SURVEILLANCE WITHIN THE SOS CENTER

- To ensure safety, transparency, and quality of care, all clinic areas are under continuous video surveillance, excluding bathrooms.
- Surveillance footage is used for safety, supervision, training, and quality assurance purposes only. Video footage is not used for marketing and is not released outside the clinic except as required by law.
- Video feeds are displayed in the designated parent viewing room.
- Your child may be visible on these monitors while receiving therapy by other parents/guardians or authorized visitors. By enrolling your child in services, you acknowledge and consent to the presence of video monitoring and the possibility that other parents/guardians may see your child on the viewing monitors.

Guardian Name | Guardian Signature | Date

Wet Signature Required

PAYMENT AGREEMENT

INSURANCE AUTHORIZATION

- I hereby authorize Success On The Spectrum ("SOS") to submit medical and therapy reimbursement claims to my health insurance carrier for services provided to my child.
- I understand and agree that any insurance pre-authorization obtained by SOS is not a guarantee of payment.

FINANCIAL RESPONSIBILITY FOR MEDICAL SERVICES

- I am ultimately financially responsible for all charges not paid by my insurance, including but not limited to co-payments, deductibles, co-insurance, denied claims, non-covered services, and any applicable fees.
- Discounts or waivers of co-payments and deductibles are not permitted by law.
- My financial responsibility applies regardless of insurance status, benefit limitations, or coverage determinations.
- SOS will bill me monthly for any balances remaining after insurance processing.
- All invoices must be paid within fifteen (15) days of the invoice date.
- If an account balance remains unpaid for more than ninety (90) days, SOS reserves the right to suspend or terminate my child's services.

NON-MEDICAL RELATED FEES

- Late payment fee assessed every fifteen (15) days an invoice remains unpaid
- Returned check fee (including NSF or stopped payments)
- Mileage fees (for in-home services and school shadowing only)
- $50 no-call/no-show fee for unannounced cancellations
- Field trip fees, when applicable
- $25 late pick-up fee for each fifteen (15) minutes after the scheduled session end time
- $1 per diaper if diapers are not supplied by the parent/guardian
- $5 forgotten lunch fee if a lunch is not provided (parent permission will be obtained prior to SOS providing food)
- Replacement or repair costs for SOS equipment or electronics damaged by my child
- Online payment processing fees, when applicable
- All collection costs, including agency fees, court costs, and reasonable attorney's fees, if a delinquent balance is referred for collection or legal action

INVOICE DISPUTES

- If I believe an invoice contains an error, I agree to notify the SOS billing department in writing within ninety (90) days of receipt of the invoice in question to allow review and consideration.
- Understand that disputes or inquiries submitted after ninety (90) days will be deemed untimely, and no refunds or adjustments will be issued for invoices older than this period.

Acknowledgment & Agreement By signing below, I acknowledge that I have read, understand, and agree to the terms of this Financial Responsibility & Payment Agreement, and I accept full responsibility for payment as outlined above.	
Guardian Name:	
Guardian Social Security:	
Guardian Birthday:	
Guardian Signature:	
Date:	

INFORMED CONSENT

VOLUNTARY ENROLLMENT & CONSENT

- I hereby voluntarily apply for and consent to the provision of behavioral health and related services by Success On The Spectrum ("SOS"), 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 SOS in accordance with applicable laws, professional standards, and my child's individualized treatment plan.

GUARDIAN PARTICIPATION & TRAINING REQUIREMENTS

- I understand and acknowledge that parent and/or guardian involvement is a required component of my child's treatment.
- I agree to participate in required Caregiver Training meetings and treatment planning and progress reviews
- I understand that SOS strongly encourages the participation of both parents or legal guardians, when applicable, to support consistency and treatment outcomes.
- Failure to participate in required parent involvement activities may impact my 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 must maintain a minimum attendance rate of 85% of scheduled sessions each month, and throughout the duration of enrollment.
- I acknowledge that chronic absenteeism, tardiness, or failure to meet attendance requirements may result in Reduced services, Modification of scheduling, Suspension or termination of services and/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 is conducted throughout the clinic, excluding restrooms
- Images and audio of my child may be captured during services
- Live video feeds will be displayed in the designated parent viewing room. 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 SOS policies and applicable privacy laws.

GUARDIAN RIGHTS TO REFUSE, WITHDRAW, OR SEEK REFERRAL

- I understand that I may request a referral to another provider if I am dissatisfied with services or progress
- I have the right to refuse or withdraw consent for services at any time
- I further acknowledge that continued participation in services constitutes ongoing voluntary informed consent.

SOS'S RIGHTS TO REFUSE OR DISCONTINUE SERVICES

- I understand and agree that Success On The Spectrum reserves the right to refuse, limit, 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.

Guardian Name | Guardian Signature | Date

Wet Signature Required

TELEHEALTH CONSENT

TELEHEALTH SERVICES

- I understand that Success On The Spectrum ("SOS") 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, and SOS may determine that in-person services or referrals are necessary
- I understand that telehealth involves the electronic transmission of information, which carries inherent risks, including potential interruptions or technical failures

PRIVACY DURING TELEHEALTH

- I will be informed if any additional personnel are present during the telehealth session beyond myself, individuals accompanying me, and the treating or supervising clinician
- I may grant or deny verbal consent for additional personnel to participate
- I may request that non-essential personnel leave the session at any time
- I may request a private consultation with the remote provider when clinically appropriate
- I acknowledge that participation in telehealth may increase the risk of privacy or security breaches, and I accept these risks.

RECORDING, DOCUMENTATION & USE OF TELEHEALTH DATA

- 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
- Such information may be maintained as 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
- SOS 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 or withdraw consent at any time, Stop participation in a telehealth session without penalty
- Request an in-person appointment, when available and clinically appropriate

Guardian Name | Guardian Signature | Date

Wet Signature Required

AI CONSENT

Success On The Spectrum (SOS) utilizes artificial intelligence (AI) technology to assist our clinical team with documenting therapy sessions, including generating and improving SOAP notes, treatment summaries, assessments, progress reports, and other clinical documentation. AI may also assist with treatment planning, evaluating progress, and improving the quality and efficiency of services. These tools may process confidential client information, including protected health information (PHI), solely for authorized purposes.

All AI-generated clinical documentation is subject to review and oversight by qualified SOS personnel, and AI does not replace the professional judgment of our clinicians. SOS will implement appropriate privacy and security safeguards consistent with applicable federal and state laws, including HIPAA.

SOS will not use client information to train AI models, conduct research, or create marketing materials without obtaining separate written consent where required by law.

By signing below, I acknowledge that I have received notice of SOS's use of AI technology and authorize SOS to use my child's confidential and personal information with AI tools for treatment planning, clinical documentation, assessments, progress evaluations, and reports related to my child's care. I understand that this authorization does not extend to AI model training, research, or marketing purposes.

Guardian Name	Guardian Signature	Date

Wet Signature Required

VIDEO SURVEILLANCE, AUDIO RECORDING & HIPAA WAIVER

VIDEO & AUDIO SURVEILLANCE NOTICE

- I acknowledge and understand that Success On The Spectrum ("SOS") utilizes continuous video and audio surveillance throughout its centers for purposes including, but not limited to, safety, supervision, quality assurance, and operational oversight. Restrooms are excluded from surveillance.
- Recorded footage is stored on password-protected, secure systems located within the center and is retained for a limited period of time before being automatically overwritten, unless required to be preserved for legal, safety, or compliance reasons.

PERMITTED USE OF RECORDINGS

- I understand and agree that video and audio recordings will not be used for marketing, advertising, or public dissemination
- Recordings may be reviewed and used 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 state and federal privacy laws.

PARENT VIEWING ROOM DISCLOSURE

- I acknowledge and understand that video feeds are displayed in the parent viewing room.
- Parents/guardians, authorized visitors, or clients may see or overhear my child while viewing these monitors
- Viewing access is a privilege and may be restricted or revoked at SOS's discretion

CONSENT TO CAPTURE, STORE & USE IMAGE AND AUDIO

- I hereby grant Success On The Spectrum irrevocable permission to capture, record, store, and maintain video and audio recordings of my child while present in the SOS center
- I acknowledge and agree that SOS shall own all rights, title, and interest in such recordings. I grant SOS the irrevocable right to use, review, store, and retain such recordings as described herein.
- I waive any right to inspect, approve, or control the use of such recordings prior to or after their use

PROHIBITION ON PARENT RECORDING & ACCESS

- I understand and agree that parents/guardians, and visitors are strictly prohibited from taking photographs, videos, or audio recordings inside the SOS facility.
- No individual may possess or obtain copies of SOS surveillance recordings except as required by court order or legal mandate

CONFIDENTIALITY OBLIGATIONS OF PARENTS & VISITORS

- I acknowledge that while present in the SOS center or parent viewing room, I may see or hear information relating to other clients. Such information is confidential and protected.
- I agree that any such information is confidential and will not be shared, recorded, discussed, or disseminated in any manner. I agree to maintain the confidentiality of all information observed or overheard and will not disclose any information regarding other clients to any third party

RELEASE OF LIABILITY & WAIVER OF CLAIMS

- I hereby release, discharge, and hold harmless Success On The Spectrum, its owners, officers, directors, employees, contractors, franchisees, and agents from any and all claims, demands, damages, or causes of action arising out of or related to the capture, storage, use, or review of video and audio recordings as permitted herein.
- This waiver includes, without limitation, claims for invasion of privacy, Right of publicity, Emotional distress, Unauthorized use of likeness
- This release shall be binding, perpetual, and irrevocable to the fullest extent permitted by law.

Guardian Name | Guardian Signature | Date

Wet Signature Required

RELEASE OF LIABILITY

VOLUNTARY ASSUMPTION OF RISK, RELEASE OF LIABILITY, INDEMNIFICATION & HOLD HARMLESS AGREEMENT

- 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"), and on behalf of their respective heirs, executors, administrators, representatives, successors, and assigns (collectively, the "Releasing Parties").
- This Agreement is made in favor of Success On The Spectrum, including but not limited to its franchisees, owners, officers, directors, shareholders, members, managers, employees, contractors, agents, representatives, parent companies, subsidiaries, and affiliates (collectively, "SOS").
- As a condition precedent to receiving behavioral health, therapy, training, supervision, or related services (the "Services"), whether provided in-center, in-home, in the community, on playground equipment, or during activities or outings, the Releasing Parties knowingly and voluntarily agree as follows:

ACKNOWLEDGMENT OF CARE, SUPERVISION & INHERENT RISKS

- I acknowledge that my Child will be under the care, supervision, and control of SOS staff while receiving Services.
- I further acknowledge and understand that behavioral health services inherently involve physical activity, movement, behaviors, emotional responses, and interaction with other children, equipment, and environments
- Despite reasonable supervision and safety procedures, injuries, accidents, or unforeseen events may occur
- Risks include, but are not limited to: slips, falls, collisions, behavioral incidents, equipment use, playground activity, and interactions with other clients
- I knowingly and voluntarily assume all risks, both known and unknown, foreseeable and unforeseeable, arising out of or related to my Child's participation in the Services.
- I specifically authorize my Child to participate in playground activities, including but not limited to trampolines, monkey bars, climbing equipment, and enclosed safety nets, when supervised by SOS staff.I understand and acknowledge that such activities carry an increased risk of injury, including serious injury or death. SOS cannot eliminate all risks despite supervision

COMPREHENSIVE RELEASE OF LIABILITY

- I understand that clients may bring personally owned items (including communication devices, tablets, electronics, toys, blankets, or specialized equipment) into the center or home sessions at their own risk. I acknowledge and agree that SOS is not responsible for loss, theft, or damage to any personal property. I hereby release SOS from any liability for damage, loss, or destruction to my personal property caused by my Child during in-home therapy sessions, Center-based services, Community or off-site activities
- To the fullest extent permitted by applicable law, the Releasing Parties assume full responsibility for any and all risks of Personal injury, Illness, Emotional distress, Property loss or damage, Permanent disability, and/or death arising from or related to participation in the Services, including risks arising from the ordinary negligence of SOS or others, except where prohibited by law.
- To the fullest extent permitted by law, the Releasing Parties hereby release, waive, discharge, and forever hold harmless SOS from any and all claims, demands, actions, causes of action, damages, losses, costs, expenses, and liabilities of any kind, whether known or unknown, suspected or unsuspected, arising out of or related to my Child's participation in the Services, my Child's presence at any SOS facility, home, playground, or community setting, Supervision, care, or control of my Child by SOS, Use of equipment, furniture, playgrounds, trampolines, monkey bars, safety nets, or therapeutic materials
- The Releasing Parties agree to defend, indemnify, and hold harmless SOS from and against any and all claims, damages, losses, liabilities, costs, and attorney's fees arising out of or related to my Child's actions or behaviors, damage or injury caused by my Child to persons or property ,claims brought by third parties as a result of my Child's participation in Services
- This release includes, where legally permitted, claims based on ordinary negligence, but does not apply to gross negligence or willful misconduct where such exclusion is prohibited by law.

INDEPENDENT FRANCHISE ACKNOWLEDGMENT & SEVERABILITY

- I acknowledge that SOS locations are independently owned and operated and are not owned or operated by SOS Franchising LLC.
- 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.

Guardian Name | Guardian Signature | Date

Wet Signature Required

SUCCESS ON THE SPECTRUM®

TRAUMA SCREENING

SOS desires to provide trauma informed care for every child. We understand that every child's past experiences will impact their current behavior. Without understanding their trauma history, we are at risk of unknowingly triggering previous trauma reactions. We understand that these situations are difficult for parents to discuss, so we will always do our best to respect your boundaries. We do ask that you be as open as possible in this form so that we can properly interact with your child and respect his/her past experiences.

TRAUMA SCREENING Mark YES if it happened to your child to the best of your knowledge. Mark NO if it didn't happen to your child.	No	Yes
Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire	☐	☐
Serious accident or injury like a car/bike crash, dog bite, or sports injury.	☐	☐
Threatened, hit or hurt badly within the family.	☐	☐
Threatened, hit or hurt badly in school or the community.	☐	☐
Attacked, stabbed, shot at or robbed by threat	☐	☐
Seeing someone in the family threatened, hit or hurt badly.	☐	☐
Seeing someone in school or the community threatened, hit or hurt badly.	☐	☐
Someone doing sexual things to the child or making the child do sexual things to them when he/she couldn't say no. Or when the child was forced or pressured	☐	☐
On line or in social media, someone asking or pressuring the child to do something sexual. Like take or send pictures	☐	☐
Someone bullying the child in person. Saying very mean things that scare him/her.	☐	☐
Someone has bullied the child online. Saying very mean things that scare him/her.	☐	☐
Someone close to the child dying suddenly or violently.	☐	☐
Stressful or scary medical procedure	☐	☐
Being around war.	☐	☐
Been kicked out of a school or daycare due to autism-related challenges or challenging behavior	☐	☐
Attended a clinic or school that used frequent punishment procedures with your child for their Challenging behaviors	☐	☐
Attended a clinic or school in which they were frequently placed into a restraint in response to Their challenging behaviors	☐	☐
History of neglect (e.g. not being fed, being left alone for periods of time, etc)	☐	☐
Has been adopted	☐	☐
Has been in the foster care system	☐	☐
Was alive when parents went through separation or divorce	☐	☐

TRAUMA SCREENING (pt 2) Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks	Never	Once In A While	50% of Time	Always
Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	☐	☐	☐	☐
Bad dreams related to a stressful event	☐	☐	☐	☐
Acting, playing or feeling as if a stressful event is happening right now.	☐	☐	☐	☐
Feeling very emotionally upset when reminded of a stressful event.	☐	☐	☐	☐
Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	☐	☐	☐	☐
Trying not to remember, talk about or have feelings about a stressful event.	☐	☐	☐	☐
Avoiding activities, people, places or things that are reminders of a stressful event	☐	☐	☐	☐
Increase in negative emotional states (afraid, angry, guilty, ashamed, confusion).	☐	☐	☐	☐
Losing interest in activities s/he enjoyed before a stressful event. Including not playing as much.	☐	☐	☐	☐
Acting socially withdrawn.	☐	☐	☐	☐
Reduction in showing positive feelings (being happy, having loving feelings).	☐	☐	☐	☐
Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.	☐	☐	☐	☐
Being overly alert or on guard.	☐	☐	☐	☐
Being jumpy or easily startled	☐	☐	☐	☐
Problems with concentration.	☐	☐	☐	☐
Trouble falling or staying asleep.	☐	☐	☐	☐
Has ever had suicidal thoughts or attempts	☐	☐	☐	☐

Please Send this page to your child's doctor AS SOON AS POSSIBLE

Dear Healthcare Provider,

Success On The Spectrum (SOS) is requesting comprehensive medical and diagnostic documentation for our mutual patient to support insurance authorization for Applied Behavior Analysis (ABA) therapy. To ensure that our clinical team has the information necessary to develop an appropriate treatment plan and satisfy applicable insurance requirements, please provide the following records:

Requested Medical Documentation

1. Referral for ABA Therapy (written within 6 months of this letter)
2. Comprehensive Autism Spectrum Disorder (ASD) Diagnostic Evaluation
    - Date of the patient's initial ASD diagnosis.
    - Diagnostic criteria assessed under the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5 or DSM-5-TR)*.
    - Names of standardized diagnostic instruments and assessment tools administered (e.g., ADOS-2, ADI-R, CARS-2, or other applicable instruments).
    - Complete diagnostic evaluation report confirming the ASD diagnosis. Must include assessment results, including raw scores, standardized scores, classification ranges, and interpretations, where applicable.
    - Documented ASD symptom severity levels, including levels of support required for social communication and restricted/repetitive behaviors.
3. Co-Occurring Medical and Behavioral Health Conditions
    - Documentation of any known or suspected co-occurring behavioral, developmental, neurological, psychiatric, or physical health disorders.
    - Relevant diagnoses, medical history, and current medications, if applicable.
4. Hearing and Vision Screening
    - Most recent hearing screening results, including the date performed.
    - Most recent vision screening results, including the date performed.
    - Any documented hearing or vision impairments, concerns, or referrals for further evaluation.
5. Depression Screening (required for kids 13 years and older)
6. Trauma Screening (if applicable)
    - Documentation of any trauma screening completed, including the date, screening instrument , and relevant clinical findings.
    - Any identified trauma-related diagnoses or clinical recommendations relevant to treatment planning.

If any requested assessment or screening has not been completed, please indicate that it is unavailable rather than leaving the request unanswered.

Please Send requested records to: Success On The Spectrum

Secure Fax:_____

Secure Email:_____@SuccessOnTheSpectrum.com

Parent/Legal Guardian Authorization for Release of Medical Information

I am the parent or legal guardian/personal representative of the patient. I authorize you to disclose the medical records and diagnostic information identified in this request to Success On The Spectrum (SOS) for the purposes of clinical evaluation, treatment planning, coordination of care, and insurance authorization.

I understand that:

- This authorization is voluntary, and I may revoke it in writing at any time, except to the extent that action has already been taken in reliance upon it.
- Information disclosed under this authorization may be subject to redisclosure as permitted by law.
- My child's treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned on signing this authorization, except where permitted by law.
- This authorization will not expire until I revoke it in writing.

Child's Name:	Guardian Name:
Child's DOB:	Guardian Signature:
Child's Gender:	Date: