Client Intake Form

Date of Intake ...../...../.....

- ☐ Early Years Therapy Group
- ☐ Art Play (Sunday Group)
- ☐ Speech
- ☐ Occupational Therapy
- ☐ Behaviour Therapy
- ☐ Art Therapy
- ☐ Social Skills Group
- ☐ Physiotherapy
- ☐ Music Therapy
- ☐ Psychology
- ☐ Young Adult Social Group

☐ Fee for Service ☐ HICAPS / Health Fund ☐ Medicare ☐ FaHCSIA/ HCWA ☐ NDIS

Client Information:			
Child's Name:		**Child's Surname:**	
D.O.B:		☐ Male	☐ Female
Street Address:			
Suburb		Postcode	
Phone Number / Mobile			
School		Year Attending	

Cultural Information	
Country of birth:	
Language(s) Spoken at Home:	
Are you of Aboriginal or Torres Strait Islander Decent?	☐ Yes ☐ No

Additional Information

How does your child communicate?

- ☐ Using words (back & forth conversation)
- ☐ Using pictures / communication device if so, What communication system do they use ? .....
- ☐ Signing (Key Word Sign, Auslan or Makaton) / Gesture / Body Language
- ☐ All of the above

Does your child have a diagnosed disability:	☐ Yes ☐ No	If so, what is the diagnosis? ..... When was the diagnosis and by whom?.....

Is this referral for the NDIS?	☐ Yes ☐ No	If yes, what is your NDIS number?	.....
How did you hear about AASS?	☐ Website ☐ Family/friends ☐ Heath professionals ☐ Other, please specify: _____		

Family Information			
Parent/Guardian/ Client Representative Name			
Phone number / Mobile			
Relationship to Child:		D.O.B:	
Occupation:		Ethnicity:	
Email address:			
Is an interpreter required?	☐ Yes Language ..... ☐ No		

Other Parent/Guardian/ Client Representative Name	
Relationship to Child:	
Siblings	Name …… Age Name …… Age Name …… Age Name …… Age

Consent for Information Collection

On behalf of my child/children, by signing below, I hereby consent to AASS to collect, maintain, store and release my information for the purposes of reporting under the Commonwealth/State and Territory Disability Agreement.

Signature:		Date:
Name of Signee:		
Relationship to the child:		

Permission to use Photograph

I give permission to Autism Advisory and Support Service (AASS) to take photographs/video of my child. I understand the photographs/video may be used for educational and/or promotional purposes in any type of media, including the website www.aass.org.au

Signature:		Date:
Name of Signee:		
Relationship to the child:		

Authorisation to Speak with Third Party

I give permission to Autism Advisory and Support Service (AASS) to make enquiries and speak on my behalf with schools, medical professionals and other related parties with regards to my child.

Signature:		Date:
Name of Signee:		
Relationship to the child:		

Office Only Date Received	Client Database			
	Date Entered	Signature	Date Entered	Signature

Autism Advisory and Support Service

"Empowering children with autism
and their families through knowledge & support"

Cancellation Policy

Autism Advisory & Support Service (AASS) provides this information to ensure that all clients are aware of the cancellation policy for all services provided. Clients should take care to read the cancellation policy applicable to the services they are accessing.

Within the NDIS operational guidelines, NDIS will cover the costs of the first two late, cancelled or no show appointments. Thereafter, and for all other methods of payment for service (eg. HCWA, Fee for Service etc), cancellation fees must be paid by the client, their family or carer.

AASS will issue invoices for cancellation fees for cancelled or missed appointments. Cancellation fees need to be paid in full before or at the time of the next therapy session.

For all services, after 3 cancellations and/or "no shows", or where fees are in arrears, services will be reviewed and may be suspended. When a client is a "no show", AASS Staff will endeavour to contact the client to determine if there is a problem or crisis that may require additional support. Where cancellation fees are not paid and no contact has been made to AASS, services will be terminated as per the Service Agreement.

Cancellation fees are as follows:

1. **Individual therapy (Occupational Therapy, Speech Therapy, Psychology, Music Therapy, Physiotherapy etc) -** less than 24 hours' notice of cancellation $40, failing to advise or show up for appointment $70
2. **Group Therapy:**
    - **Early Years Therapy Group, Social Skills Therapy Group and Music Therapy Group -**less than 24 hours' notice $20, failing to advise or show up for appointment $35
3. **Behaviour Support Intervention -** less than 24 hours' notice $90, failing to advise or show up for appointment $150
4. **Case Coordination or Specialist Support Coordination -** less than 24 hours' notice $30, failing to advise or show up for appointment $60

I confirm that I have read and understood this policy and agree to abide by the terms contained therein.

Participant/Participant Representative Name: _____

Signature: _____

Date: _____

Left Blank

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