Client Intake Form

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

☐ Fee for Service ☐ HICAPS / Health Fund ☐ Medicare ☐ NDIS Number _____ (attach plan)

Client Information:	
Client's Name:	D.O.B:
Client's Surname:	☐ Male ☐ Other (please specify) ☐ Female
Street Address:	
Suburb:	Postcode:
Phone Number / Mobile:	
School:	Year Attending:
Preferred Method of Contact ☐ Phone ☐ Email (please supply)	
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 the Client communicate? ☐ Using words (Yes or No) ☐ Using pictures / communication device if so , please specify below What communication system do they use ? ..... ☐ Signing (Key Word Sign, Auslan or Makaton) / Gesture / Body Language ☐ No Communication	
Does the Client have a diagnosed diagnosis? ☐ Yes ☐ No	Please list diagnosis: ..... When was the diagnosis and by whom?.....
How did you hear about AASS? ☐ Website ☐ Family/friends ☐ Heath professionals ☐ Other, please specify: _____	

Services you want to apply for:

☐ Psychology ☐ Occupational Therapy ☐ Art Therapy

☐ Physiotherapy ☐ Social Skills Group (7-15 yrs.) ☐ Art Play (Sunday Group)

☐ Speech Therapy ☐ Young Adult Social Group (16-24 yrs.) ☐ Behaviour Support (Improved Daily Living in NDIS plan)

☐ Music Therapy ☐ Early Years Therapy Group (0-5 yrs. Pre-school children)

Family Information		
Parent/Guardian/ Client Representative Name: Same Home Address ☐ Yes ☐ No		
Address:		
Suburb:	Postcode:	
Phone number / Mobile		
Relationship to Client:	D.O.B	
Occupation:	Country of Birth	
Email address:		
Is an interpreter required? ☐ No ☐ Yes Language:		
Other Parent/Guardian/ Client Representative Name Same Home Address ☐ Yes ☐ No Does this person have Authority to access information/ receive correspondence? ☐ Yes ☐ No		
Address:		
Suburb:	Postcode:	
Phone number / Mobile		
Relationship to Client:	D.O.B:	
Occupation:	Country of Birth:	
Email address:		
Is an interpreter required? ☐ No ☐ Yes Language:		
Does this person have Authority to access information/ receive correspondence? ☐ Yes ☐ No		
Siblings: Name …… Age…….. Additional needs ☐ Yes ☐ No Name …… Age…….. Additional needs ☐ Yes ☐ No Name …… Age…….. Additional needs ☐ Yes ☐ No Name …… Age…….. Additional needs ☐ Yes ☐ No		
Authorisation to Speak with Third Party	☐ Yes ☐ No	MUST BE ANSWERED
Consent for Information Collection (collect, maintain, store and release my information for the purposes of reporting under the Commonwealth/State and Territory Disability Agreement).	☐ Yes ☐ No	
Photographs/video may be used for educational purposes	☐ Yes ☐ No	
Photographs/video may be used for promotional purposes including the website	☐ Yes ☐ No	
Signature:	Date:	
Name of Signee:		
Relationship to the Client:		

Please complete the following selections for the services you are applying for……

What are your main priorities for your child at this time? ***(Please rate in order of priority, 1 being most)***

- ☐ Communication
- ☐ Gross Motor
- ☐ Challenging Behaviours
- ☐ Social Skills
- ☐ Sensory Issues
- ☐ Anxiety/Mental Health
- ☐ Play Skills
- ☐ Fine motor
- ☐ Feeding / Swallowing
- ☐ School / Preschool skills
- ☐ Self-care (e.g. dressing, showering, toileting)
- ☐ Other: _____

Psychology

- ☐ Anxiety Management
- ☐ Problem Behaviours
- ☐ Learning Difficulties
- ☐ Anger Management
- ☐ School Concerns
- ☐ Social Skills
- ☐ Emotion Regulation
- ☐ Other: _____

Speech Therapy

- ☐ Communication
- ☐ Augmentative & Alternate Communication System
- ☐ Social Skills
- ☐ Play Skills
- ☐ Eating & Drinking Difficulty
- ☐ Literacy
- ☐ Fussy Eating
- ☐ Speech Sounds
- ☐ Other: _____

Music Therapy

- ☐ Social Skills
- ☐ Fine Motor
- ☐ Group Music Therapy
- ☐ Improve attention
- ☐ Independence
- ☐ Communication
- ☐ Play Skills
- ☐ Gross Motor
- ☐ Emotional Regulation
- ☐ Other: _____

Occupational Therapy

- ☐ Gross Motor
- ☐ Self-Care
- ☐ Fine Motor
- ☐ Emotion Regulation
- ☐ Sensory
- ☐ Other: _____

Art Therapy

- ☐ Communication
- ☐ Sensory exploration
- ☐ Social skills
- ☐ Emotional regulation
- ☐ Motor skills
- ☐ Other: _____
- ☐ Self-Care

Cancellation Policy

This Cancellation Policy applies to all clients from 1 July, 2020 and replaces our previous cancellation policies

Cancellation Fees are charged when:

- You fail to advise or fail to show up for a service (no show).
- You notify us of cancelling an appointment within two (2) full business days of, or on the day of the service being provided (late notice).

Please contact the office on (02)9601 2844 (leave a message if unattended) or call or text your therapist directly.
We ask that you contact us as soon as you can in relation to any cancellation regardless of location of therapy (clinic, school or home based therapy).
Cancellation Fees will be charged as follows:

	NDIS	**Fee for Service/ Medicare/HCWA**
Cancel more than two (2) full business days before the appointment (late notice)	No charge to the NDIS Plan	No charge
Cancel within two (2) full business days of the appointment (late notice)	100% of NDIS session fee charged to the NDIS plan (no limit)	50% of the session fee will be charged (out of pocket)
Failing to Advise or "No Show" for appointment	100% of NDIS session fee charged to the NDIS plan (no limit)	Full session fee (out of pocket)

AASS will issue invoices for out of pocket cancellation fees for cancelled or missed appointments. These fees are payable by yourself personally.

ALL OUT OF POCKET CANCELLATION FEES MUST BE PAID BEFORE THE NEXT THERAPY SESSION.

Cancellation or Suspension of Services:

Your services may be cancelled and referred to another provider if:

- You reach more than 6 cancellations in a calendar year
- Fees and/or Cancellation Fees are unpaid or in arrears

To reduce cancellations, AASS sends out scheduled SMS reminders of your scheduled appointments if you provide a mobile phone contact number.
When three cancellations are reached, AASS staff will attempt to contact you to determine what is affecting your continuity of service and discuss if alternative arrangements or extra support is needed in relation to your services at AASS.

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: _____

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