***Behavioral Directions, LLC 2014 Summer ABA Clinic Schedule***

We are excited to announce that enrollment is now open for our clinic-based summer Applied Behavior Analysis (ABA) instructional clinic, under the direction of Dr. Jane Barbin, Licensed Clinical Psychologist and Licensed/Certified Behavior Analyst-Doctoral. Our fee schedule for the upcoming summer session remains the same as last summer. After an initial screening evaluation, we offer a 4 day/week (**ONE to ONE RATIO) individualized instructional program** for your child in our office. Individualized curriculum programming will be developed, with corresponding data tracked to measure progress. Weekly progress reports will be sent home. Dr. Barbin will directly monitor progress and at the close of each session, she will meet with the parents to review the child’s progress and progress data will be disseminated to the parents. Sessions are for 3 or 6 weeks in length (2 hours per day), with strong encouragement for 6 week enrollment spots to maximize benefit.

Space is **limited** and slots are secured on a first come, first serve basis, with consideration given to prerequisite criteria. Full tuition is due in advance of the clinic, with a 50% deposit to secure the spot. The last date for a full refund is 30 days prior to session start, without exception. Please note that there will be one make-up session allowed for the summer in the case of illness. All other cancellations will not be refunded or rescheduled. We ask you to keep your child home if s/he has a fever, diarrhea, vomiting, or other illness until free of symptoms for 24 hours.

For current and returning clients, the screening process will take place on an as-needed basis. For clients new to Behavioral Directions, LLC an initial screening interview (approximately 30-minutes) will be conducted at no charge before any slot will be filled. Thereafter an Intake Evaluation will be conducted and a written, detailed report of recommendations provided (approximate cost $1800 due at time of appointment and prior to start of summer clinic). Evaluation will determine fit for the program. In the event that the intake evaluation determines the child is not an appropriate fit for the clinic, clinic tuition will be refunded, however the evaluation fee is not refundable. Availability of additional services following clinic sessions are not guaranteed, though may be available under a separate contractual agreement.

ABA Instruction by **Trained ABA Instructor** : Kirsten Kennedy, BA, BCaBA candidate. Ms. Kennedy has been trained in Behavioral Directions’ manualized treatment model and has worked in home-based ABA settings providing direct instruction to learners with autism spectrum and behavior disorders for the last few years under Dr. Barbin’s direction. She has completed training and supervision requirements in the field of behavior analysis and has recently taken the Behavior Analyst Certification Board exam for certification as an Associate Behavior Analyst.  **Indicate Schedule Preference on Following Pages.**

SESSIONS ARE ON WEEKDAYS FROM MONDAY THROUGH THURSDAY.

SESSIONS ARE FROM EITHER 10am - 12pm OR 12:30pm - 2:30pm (indicate preference)

**Cost:** $2150.00 per 3 week session ($4300.00 per 6 week session-check Session A and B)

**Session A: June 30- July 17 : Please select schedule you are requesting:**

***SCHEDULE #1 (MORNING):***

\_\_\_\_\_\_ 10am – 12pm

***SCHEDULE #2 (EARLY AFTERNOON):***

\_\_\_\_\_\_ 12:30pm – 2:30 pm

**Session B: July 21 – August 7 : Please select schedule you are requesting:**

***SCHEDULE #1 (MORNING):***

\_\_\_\_\_\_ 10am – 12pm

***SCHEDULE #2 (EARLY AFTERNOON):***

\_\_\_\_\_\_ 12:30pm – 2:30 pm

\*Submit a REGISTRATION FORM along with a 50% deposit to secure your selection.

***Registration Form***

***Behavioral Directions, LLC 2014 Summer ABA Clinic***

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Person Completing Form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street

 City State Zip

PARENT(S) / GUARDIAN(S):

Mother’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone H)\_\_\_\_\_\_\_\_\_\_\_\_\_ W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone (Cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone H)\_\_\_\_\_\_\_\_\_\_\_\_\_ W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone (Cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stepparent/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone H)\_\_\_\_\_\_\_\_\_\_\_\_\_ W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are parents separated or divorced? Y N If so, for how long? \_\_\_\_\_\_\_\_\_\_\_\_

If divorced, we must ask who has legal custody of the child (both parents/mother only/father only):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who resides in the home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Anyone else involved in client’s care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings (Names and Ages):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Class: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ratio: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attending ESY (if so, indicate location and times): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Physician (or Neurologist/Psychiatrist): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What diagnoses have been made (medical/psychiatric)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 By whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Current Medication / Dose Reason Taken

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child allergic to anything\*\*? Y N If YES, please explain:

*\*\*Please be aware that we will require parents to provide any reinforcers or edibles for clinic use.*

Who referred you to our services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Session Schedule Requested:**

(Select only ONE TIME per session though multiple 3-week SESSIONS may be reserved).

Select SESSION(S) then circle TIME requested:

\_\_\_\_\_**Session A** (June 30- July 17, 2013)- Morning OR Early Afternoon

\_\_\_\_\_**Session B** (July 21 - August 7, 2013)- Morning OR Early Afternoon

For Office Use:

Date of Intake Evaluation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Session/Schedule Confirmed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date paid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)