UW AUTISM CENTER
UNIVERSITY of WASHINGTON
Center on Human Development & Disability

Registration Form

Date Completed:___/___/ _____
Site Requested: Seattle Tacoma

Patient Information:

Name: _____, _____, _____
Last First Middle

Date of Birth: ___/___ /_____ Last Four Digits of SSN: _____ Gender: _____

Address: _____

Ethnicity: ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other _____

Person Completing this Form:

If someone other than the client is filling out the form, please answer the following questions:

Name: _____, _____Parent____Guardian____Other: _____
Last First

Are you authorized to consent for this individual's healthcare? ___Yes ___No

Insurance Information: Primary Insurance Coverage

Insurance Company Name_____Name of Benefit Plan: _____

Subscriber Name:_____, _____ DOB:____/___/_____ SSN:_____-___-_____
Last First

Patient Relationship to Subscriber:_____Self_____Dependent_____Spouse_____Other: _____

ID #:_____Group Number:_____Provider Phone Number: _____

Insurance Address: _____

Insurance Information: Secondary Insurance Coverage

Insurance Company Name_____Name of Benefit Plan: _____

Subscriber Name:_____, _____ DOB:____/___/_____ SSN:_____-___-_____
Last First

Patient Relationship to Subscriber:_____Self_____Dependent_____Spouse_____Other: _____

ID #:_____Group Number:_____Provider Phone Number: _____

Insurance Address: _____

Guarantor:

Individual responsible for any expenses not covered by insurance

Name:_____,_____Relationship to Client:_____Phone: _____
Last First

Address: (□Same as above)_____

Legal Next of Kin:

Individual can make decisions for client in an emergency

Name:_____,_____Relationship to Client:_____Phone: _____
Last First

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Date Completed:____/____/ _____

Primary Healthcare Provider:

Primary Care Physician:_____Clinic/Hospital: _____

Phone Number:_____Address: _____

Household and Family Information:

Patient's Relationship Status:_____Single_____Married_____Divorced/ Separated_____Other: _____

If living with parents, are parents divorced or separated? ____Yes ____No

If Yes, please indicate the type of custody:_____Joint_____Sole Name: _____
Who is responsible for medical decisions regarding the client: _____

Primary Language Spoken in the Home:_____Other Languages Spoken: _____

Services Being Pursued:

Please indicate which service(s) you are interested in pursuing at the UW Autism Center:

___ Autism Evaluation ___Re-evaluation ___Medical Consultation ___Sleep Consult Clinic

___ Infant Clinic ___ Speech Therapy ___Social Skills Group ___Psychological Therapy

___ ABA Therapy: (check one or more)

□Intensive in-Home Program □Parent Coaching □Client Focused Skills Coaching

□Short-Term Consultation

Additional Questions and Comments:

Who referred you for services? _____

Has patient been diagnosed with Autism? ___Yes if yes, when and by whom? _____

_____

What are some of your concerns or the referral sources concerns regarding the client?

_____

_____

Additional Comments (optional):

_____

_____

Client Communication Agreement

The UW Autism Center would like to know your preferences by which we may contact you regarding your services.

I do not have a preference, UW Autism Center may contact me using either email or phone ☐ No ☐ Yes

I prefer the majority of all contact to take place via phone ☐ No ☐ Yes
If yes, please indicate below best contact number(s):

Home Number:_____ Best time(s) to call: _____
Is it ok to leave a message at this number? ☐ No ☐ Yes

Work Number: _____ Best time(s) to call: _____
Is it ok to leave a message at this number? ☐ No ☐ Yes

Cell Number: _____ Best time(s) to call: _____
Is it ok to leave a message at this number? ☐ No ☐ Yes

I prefer the majority of all contact to take place via email ☐ No ☐ Yes
If yes, please review and sign the consent for email below:

Individual Providers and clients may decide to use email to facilitate communication. Some Providers at UW Autism Center may communicate via email, but this agreement does not obligate all UW Autism Center Providers to communicate via email. Email may be one of many forms of communication with UW Autism Center.

Risk of using email
I want to use email to communicate to UW Autism Center Providers and staff about my/the client's personal health care. I understand that UW Autism Center Providers and staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may affect the privacy of my personal health care information when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Email may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.
- Email delivery is not guaranteed.

Conditions for the use of email
I agree that I must not use email for medical emergencies or to send time sensitive information to my/the client's Providers. I understand and agree that it is my responsibility to follow up with UW Autism Center Providers or staff, if I have not received a response to my email within a reasonable time period.

I agree that the content of my email messages should state my question or concern briefly and clearly and include (1) the subject of the message in the subject line, and (2) clear identification including client's name, parent's name, and telephone number in the body of the message. I agree it is my responsibility to inform UW Autism Center of any changes to my email address. I agree that, if I want to withdraw my consent to use email communications about my/the client's healthcare, it is my responsibility to inform my/the client's Providers or staff member only by email or written communication

Understanding the use of email
I give permission to UW Autism Center Providers and staff to send me email messages that include my/the client's personal health care information and understand that my email messages may be included in my/the patient's medical record. I have read and understand the risks of using email as stated above and agree that email messages may include protected health information about me/the client, whenever necessary.

Email address: _____

Print client's name_____

_____

Signature (Parent/Guardian if under 18) **Date**

_____

Printed Name **Relationship to client**

_____

Signature of Client (if client is 13yrs or older) **Date**