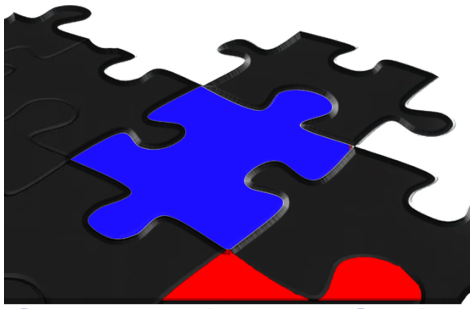

CT ABA SERVICES LLC
1000 Lafayette Blvd
Suite 1100
Bridgeport, CT 06604-4710

CLIENT INTAKE ENROLLMENT PACKET

CT ABA SERVICES LLC
CLIENT INTAKE ENROLLMENT PACKET
1000 Lafayette Blvd, Suite 1100
Bridgeport, CT 06604-4710
Phone: (203) 906-5328

Version 1.1 | Effective August 17, 2026

Welcome to CT ABA Services LLC. This packet contains the forms and notices required to begin Applied Behavior Analysis (ABA) services. Please review each section carefully, complete all applicable fields, and sign where indicated. If you have any questions, please do not hesitate to contact us.

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TABLE OF CONTENTS

**BE SURE THE ADE, IEP, and any other documents pertaining to diagnosis are submitted/collected to initiate this process.

SECTION 1: CLIENT INFORMATION AND INTAKE FORM

Version 1.1, Effective August 17, 2026

|

2. INSURANCE INFORMATION

Primary Insurance Provider: _____ Policy Number: _____
Group Number: _____

Medicaid/HUSKY Health ID Number (if applicable): _____

Secondary Insurance (if applicable):

Provider: _____ Policy Number: _____
Group Number: _____

3. CLIENT INFORMATION

Full Name (Client): _____ Date of Birth: _____
Gender: _____

Address: _____
City: _____ State: _____ Zip Code: _____

4. PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____ Relationship to Client: _____

Phone Number (Primary): _____ Phone Number (Secondary): _____

Email Address: _____

Preferred Contact Method: [ ] Phone [ ] Email [ ] Text

Preferred Language: _____ Interpreter Needed: [ ] Yes [ ] No

Custody or guardianship documentation on file: [ ] Yes [ ] No

5. EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Phone Number: _____

This individual will be contacted in the event of an emergency if the Parent/Guardian cannot be reached.

6. MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____

Date of Autism Diagnosis: _____ Diagnosing Physician/Clinician: _____

Co-occurring medical conditions or allergies: [ ] Yes [ ] No

If yes, please provide details: _____

7. CURRENT MEDICATIONS

Please list all medications the client is currently taking:

Medication Name	Dosage	Frequency	Prescribing Physician	Purpose/Reason

If the client takes more than five (5) medications, please attach a separate list.

Seizure disorder: [ ] Yes [ ] No If yes: Type: _____ Frequency: _____
Date of last seizure: _____

Elopement risk: [ ] Yes [ ] No

8. FAMILY HISTORY

Is there a family history of Autism Spectrum Disorder (ASD) or other developmental, behavioral, or genetic conditions?

[ ] Yes [ ] No

If yes, please describe (include relationship to Client and condition):

_____

9. CURRENT RELATED SERVICES

Is the client currently receiving any of the following services? (Check all that apply)

- [ ] Occupational Therapy (OT): Provider/Agency: _____ Frequency: _____/wk
- [ ] Physical Therapy (PT): Provider/Agency: _____ Frequency: _____/wk
- [ ] Speech-Language Therapy (SLP/Speech): Provider/Agency: _____ Frequency: _____/wk
- [ ] Psychological/Psychiatric Services: Provider/Agency: _____ Frequency: _____/wk

- [ ] Other therapy or related service: _____ Provider/Agency: _____ Frequency: _____/wk
- [ ] None

10. EDUCATIONAL INFORMATION AND BEHAVIORAL HISTORY

EDUCATIONAL INFORMATION

Current School/Program: _____ Grade/Classroom Type: _____

Individualized Education Plan (IEP) in place: [ ] Yes [ ] No If yes, please provide a copy if available.

BEHAVIORAL HISTORY

Has the individual received behavioral therapy or ABA services in the past: [ ] Yes [ ] No

If yes: Provider Name: _____ Dates of Service: _____ Reason for Discontinuation: _____

11. COMMUNICATION AND SENSORY SENSITIVITIES

COMMUNICATION

Communication Preferences (check all that apply):

[ ] Verbal [ ] Non-verbal [ ] AAC Device [ ] Sign Language [ ] PECS

SENSORY SENSITIVITIES

Please describe any specific sensory sensitivities or triggers:

_____
_____
_____
_____

12. CLIENT AND FAMILY STRENGTHS; CULTURAL, SPIRITUAL, AND PERSONAL CONSIDERATIONS

CLIENT AND FAMILY STRENGTHS

Please describe the strengths and positives of the client and the family. These may include skills the client has already developed, interests, personality traits, family supports, routines that work well, or anything you feel is going well:

_____
_____
_____
_____
_____

CULTURAL, SPIRITUAL, AND PERSONAL CONSIDERATIONS

Does the client and/or family have any spiritual, religious, or cultural values, practices, or preferences that may impact treatment planning or service delivery (for example: dietary restrictions, religious observances affecting scheduling, cultural practices, language preferences, gender preferences for therapists, or other considerations)?

[ ] Yes [ ] No

If yes, please describe: _____

13. COMMUNITY RESOURCES AND SERVICE PREFERENCES

COMMUNITY RESOURCES

Does the family currently use any community resources? (Check all that apply)

- [ ] Support groups (autism, disability, or parent support)
- [ ] Social services (DCF, DSS, 211, etc.)
- [ ] School-based services (beyond IEP)
- [ ] Respite care
- [ ] Recreational or adaptive programs
- [ ] Religious or faith-based supports
- [ ] Other: _____
- [ ] None at this time

SERVICE PREFERENCES

Preferred Service Location (check all that apply):

- [ ] Home
- [ ] Clinic
- [ ] School
- [ ] Community (library, park, etc.)
- [ ] Other: _____

Preferred Service Days (check all that apply):

- [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday

Preferred Time (check all that apply):

- [ ] Morning (8am-12pm) [ ] Afternoon (12pm-4pm) [ ] After School (3pm-6pm) [ ] Evening (after 5pm)

Additional scheduling notes or constraints: _____

14. ADDITIONAL INFORMATION

Is there any additional information you would like to share about the individual's needs, preferences, or circumstances that has not been captured elsewhere in this form?

_____

_____

_____

15. CERTIFICATION AND SIGNATURE

Guardian Copy: You are entitled to receive a copy of this completed form for your records. Please request a copy from CT ABA Services LLC staff at the time of signing.

I certify that the information provided in this intake application is accurate to the best of my knowledge. I understand that this information will be used for the purpose of planning and providing appropriate ABA services for the above-named individual.

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signature: _____

SECTION 2: CONSENT TO TREATMENT

Client ID#: _____

Client's Name: _____ DOB: _____

Parent or Guardian: _____ Relationship to Client: _____

Address: _____

City: _____ State: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

(a) PURPOSE AND SCOPE OF ABA SERVICES: CT ABA Services LLC provides individualized, evidence-based ABA therapy to increase communication, social, adaptive, and daily living skills; improve independence; reduce interfering behaviors; provide caregiver training; and support collaboration with other providers. Services are supervised by a BCBA and delivered by RBTs under supervision.

(b) NATURE OF ABA TREATMENT: 2.1 Direct 1:1 Therapy: Delivered in home, community, clinic, or school settings, including structured teaching, naturalistic teaching, play-based learning, and skill-building. 2.2 Behavior Reduction and Intervention Plans: Functional Behavior Assessments, trigger identification, preventative strategies, replacement behaviors, reinforcement, and data-driven modifications. Restrictive procedures require additional written consent. 2.3 Skill Acquisition Programs: Communication, social interaction, emotional regulation, toilet training, feeding, daily living, and academic skills. 2.4 Parent/Caregiver Training and Participation: Coaching, goal understanding, home carryover, and behavior principles education. Caregiver participation is required for treatment success. Research demonstrates that behavioral change and skill development require consistent reinforcement across all settings. The strategies taught during parent training sessions and throughout the course of services must be actively implemented in the home and community for treatment to be effective. Parent/caregiver obligations are further detailed in the Parent/Caregiver Participation and Attendance Agreement (Section 5 of this packet), which outlines specific participation and attendance requirements and the consequences of non-compliance, including possible suspension of services and continued financial obligation. 2.5 Supervision and Team Collaboration: BCBA observation, data review, program adjustment, and caregiver meetings. Collaboration with outside providers requires separate written consent.

(c) RISKS, LIMITATIONS, AND EXPECTED BENEFITS: 3.1 Expected Benefits: Improved communication, reduced interfering behaviors, increased independence, and improved social and coping skills. Results vary by individual. 3.2 Potential Risks: Temporary increases in challenging behavior, frustration, incomplete skill mastery, and progress dependent on attendance, home support, and caregiver participation. 3.3 No Guarantees: CT ABA Services LLC cannot guarantee specific outcomes or timelines.

(d) CONFIDENTIALITY AND HIPAA COMPLIANCE: All information is protected per HIPAA, Connecticut state law, and applicable ethical standards. Information is shared only with the parent/guardian, authorized clinical staff, insurance providers (for authorization and billing), and other professionals with a signed authorization. All systems are HIPAA-compliant. Refer to the Notice of Privacy Practices (Section 3 of this packet).

(e) ATTENDANCE, COMMUNICATION, AND SAFETY: 5.1 Attendance: Consistent attendance is required. A strict 24-hour cancellation notice is required. Three or more cancellations within 60 days will trigger a mandatory schedule review. Failure to comply may result in suspension of services as described in the Parent/Caregiver Participation and Attendance Agreement (Section 5 of this packet). 5.2 Communication: Parent/Guardian shall maintain up-to-date contact information and notify CT ABA Services LLC of any changes. 5.3 Safety: No smoking during sessions, pets must be secured, no aggression toward staff, and a safe and clean environment must be maintained. Unsafe environments may result in paused services.

(f) TELEHEALTH CONSENT: Supervision, parent training, treatment planning, and assessments may be conducted via Microsoft Teams. Technical issues may occur. Parent/Guardian may withdraw telehealth consent at any time.

(g) EMERGENCY POLICY: CT ABA Services LLC does not provide crisis intervention services. In an emergency, call 911. Providers may discontinue a session if safety is compromised.

(h) DATA COLLECTION AND VIDEO/AUDIO RECORDING: Ongoing data collection is required as part of treatment. Video or audio recording for supervision, treatment integrity, and training purposes is optional. All recordings are for internal use only, maintained confidentially, retained for three years, and then securely destroyed.

[ ] Yes, I consent to video/audio recording for supervision, treatment integrity, and training purposes.

[ ] No, I do not consent to video/audio recording.

(i) CONSENT TO TREATMENT: By signing below, I acknowledge that I have read and understand this form; I understand the purpose, nature, risks, and expected benefits of ABA services; I voluntarily consent to treatment for the Client named above; I have received and agree to the Parent/Caregiver Participation and Attendance Agreement (Section 5 of this packet); I understand I may withdraw consent at any time in writing; and all my questions have been answered to my satisfaction.

Client Name (Printed): _____

Parent/Guardian Name (Printed): _____

Signature: _____ Date: _____

Client Signature (if appropriate): _____ Date: _____

CT ABA Services LLC Administrator (Printed): _____

Signature: _____ Date: _____

Assigned BCBA (Printed): _____ Signature: _____ Date: _____

SECTION 3: NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: August 17, 2026

CT ABA Services LLC is committed to protecting the privacy of your Protected Health Information ("PHI"). We are required by law to maintain the privacy of PHI, provide this Notice, and notify you of any breach of unsecured PHI.

1. USES AND DISCLOSURES OF PHI: We may use or disclose PHI without authorization for Treatment (e.g., BCBA sharing information with an RBT), Payment (e.g., submitting diagnosis and procedure codes to your insurer), and Health Care Operations (e.g., quality improvement, training, compliance activities).
2. OTHER PERMITTED DISCLOSURES: As required by law; public health activities; reports of abuse or neglect to DCF; health oversight agencies; judicial or administrative proceedings pursuant to court order; law enforcement purposes; to avert a serious threat to health or safety; workers' compensation; coroners and funeral directors; and government functions as permitted by law.
3. USES REQUIRING AUTHORIZATION: Marketing, sale of PHI, psychotherapy notes, and all other uses not described above require your written authorization. You may revoke any authorization in writing at any time.
4. YOUR RIGHTS: You have the right to request restrictions on uses and disclosures; request confidential communications; inspect and copy your PHI (within 30 days); request amendments; receive an accounting of disclosures; obtain a paper copy of this Notice; and receive breach notification.
5. OUR DUTIES: We are required to maintain the privacy and security of your PHI, provide this Notice, abide by its terms, and notify you of any breach. We may revise our practices and will provide an updated Notice.
6. COMPLAINTS: If you believe your privacy rights have been violated, contact Celina Bustamante, Chief Officer of Operations, at (475) 439-2530 or cb@ctabaservices.com. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights: 200 Independence Ave SW, Room 509F, Washington, DC 20201; (800) 368-1019; OCRComplaint@hhs.gov; https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf. You will not be retaliated against for filing a complaint.

SECTION 4: ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Client Name: _____ Date of Birth: _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of CT ABA Services LLC, effective August 17, 2026. I understand that this Notice describes how my (or my child's) protected health information may be used and disclosed by CT ABA Services LLC and how I may access this information. I have been given the opportunity to read the Notice of Privacy Practices in full before signing this Acknowledgment. I understand that CT ABA Services LLC may change its privacy practices from time to time and that any revised Notice of Privacy Practices will be made available to me upon request.
Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

For questions regarding the Notice of Privacy Practices, please contact: Celina Bustamante, Chief Officer of Operations, Phone: (475) 439-2530, Email: cb@ctabaservices.com.

OFFICE USE ONLY
If the individual did not sign this Acknowledgment, indicate the reason below:

- [ ] Individual refused to sign
- [ ] Emergency circumstances prevented obtaining signature
- [ ] Communication barrier (specify): _____
- [ ] Other (specify): _____

Staff Initials: _____ Date: _____
Good faith effort made to obtain acknowledgment: [ ] Yes

SECTION 5: PARENT/CAREGIVER PARTICIPATION AND ATTENDANCE AGREEMENT

Client Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Relationship to Client: _____

Coverage Type (complete with staff): [ ] HUSKY Health/Medicaid [ ] Private/Commercial Insurance [ ] Self-Pay

Applied Behavior Analysis (ABA) is an evidence-based treatment that requires consistent implementation across every environment in which the client lives, learns, and plays. Treatment outcomes are directly linked to the degree to which parents and caregivers actively reinforce the behavioral strategies and skill-building techniques introduced during therapy.

When caregivers consistently apply the strategies taught by the clinical team, the client is more likely to generalize newly acquired skills to everyday settings, maintain behavioral improvements over time, and achieve meaningful and lasting developmental progress. When behavioral strategies are not reinforced outside of therapy sessions, progress may stall, regress, or fail to generalize, which compromises the effectiveness of the entire treatment plan.

For these reasons, CT ABA Services LLC requires all parents and caregivers to participate actively in the treatment process as outlined in this agreement. This agreement is a condition of continued enrollment in services.

1. CAREGIVER PARTICIPATION OBLIGATIONS

By signing this Agreement, I understand and agree to the following:

1.1 Parent/Caregiver Training Participation. I will attend and actively participate in all scheduled parent/caregiver training sessions conducted by the assigned BCBA or designated clinical staff. I will make a good-faith effort to learn the behavioral strategies, reinforcement techniques, prompting procedures, and skill-building methods taught during training. I will ask questions when I do not understand a strategy or recommendation.

1.2 Reinforcement of Behavioral Strategies. I will consistently implement and reinforce the behavioral strategies taught to me during parent training sessions in the home, community, and other natural environments, including:

a) Reinforcement schedules and procedures identified in the Treatment Plan or Behavior Intervention Plan (BIP);
b) Prompting and fading strategies for skill acquisition targets;
c) Antecedent modifications and environmental arrangements recommended by the BCBA;
d) Replacement behaviors identified as alternatives to challenging behaviors;
e) Communication strategies, including use of AAC devices, PECS, or functional communication training targets;
f) Generalization and maintenance procedures for mastered skills;
g) De-escalation and safety protocols.

1.3 Clinical Basis for Caregiver Reinforcement. ABA therapy occurs for a limited number of hours per week; the Client spends the majority of time in the care of parents and caregivers. Behavioral change requires consistency across all settings. Caregiver participation is a clinical requirement that directly affects the Client's progress.

1.4 Communication and Collaboration. I will maintain open and timely communication with the clinical team regarding progress, concerns, behavioral changes, and any barriers to implementing strategies. I will notify the BCBA promptly if I am unable to implement a recommended strategy. I will participate in team meetings, progress reviews, and treatment plan updates as scheduled.

2. ATTENDANCE OBLIGATIONS (ALL CLIENTS)

By signing this Agreement, I understand and agree to the following attendance obligations, which apply to all Clients regardless of payer or coverage type:

2.1 Session Attendance. I will ensure the Client is available and prepared for all scheduled therapy sessions. A responsible adult must be present in the home or at the service location during every scheduled session.

2.2 Cancellation Notice. I will provide at least twenty-four (24) hours advance notice to cancel any scheduled session. This requirement applies to all Clients regardless of payer.
2.3 Punctuality. Sessions begin at the scheduled start time. If the Client is not available within fifteen (15) minutes of the scheduled start time without prior notice, the session may be recorded as a no-show.
2.4 Excessive Cancellations: Clinical Consequences (All Clients, All Payers). Three (3) or more cancellations within a sixty (60) day period will trigger a mandatory review of the service schedule by the clinical team. Excessive cancellations may result in:

h) A reduction of authorized therapy hours;
i) A modification of the service schedule;
j) A required meeting with the BCBA and CT ABA Services LLC management to discuss continued enrollment;
k) Suspension of services as described in Section 4.

I understand that excessive cancellations may cause my insurance carrier or HUSKY Health to reduce or deny future authorizations for ABA services, because payers evaluate utilization when approving continued treatment.

3. LATE CANCELLATION AND NO-SHOW FEES

3.1 Private Insurance and Self-Pay Clients. Late cancellations (less than twenty-four (24) hours' notice) and no-shows are subject to a fee of $50.00 per occurrence. This fee will be billed directly to the Parent/Guardian or charged to the payment method on file if authorized under the Payment Authorization and Credit Card on File Agreement.
3.2 HUSKY Health and Medicaid Clients: No Fee Will Be Charged.
[CALLOUT BOX] If my child is enrolled in HUSKY Health or Medicaid, CT ABA Services LLC will NOT charge me any fee for a missed, late-cancelled, or no-show appointment. Federal and Connecticut law (42 CFR Section 447.15; CMAP Provider Bulletin PB 2015-05) prohibit charging Medicaid members for missed appointments. CT ABA Services LLC will not require me to place a deposit or maintain a payment method on file as a condition of receiving services. All clinical consequences described in Section 2.4, including mandatory schedule review, possible reduction of authorized hours, required meetings with the clinical team, and suspension of services under Section 4, remain fully applicable regardless of payer. Attendance is a clinical requirement. [END CALLOUT BOX]

4. CONSEQUENCES OF NON-COMPLIANCE (ALL CLIENTS, ALL PAYERS)

4.1 Suspension of Services. CT ABA Services LLC reserves the right to suspend or discontinue ABA services for repeated non-compliance, including: (a) failure to attend or participate in scheduled parent/caregiver training; (b) consistent failure to reinforce behavioral strategies as directed; (c) excessive session cancellations or no-shows; (d) failure to maintain communication with the clinical team; or (e) failure to provide a safe environment for therapy sessions.
4.2 Pre-Suspension Process. Before suspending services, CT ABA Services LLC will: (a) provide written notice identifying the specific areas of non-compliance; (b) schedule a meeting to discuss barriers, provide support, and develop a corrective action plan; and (c) allow not less than fourteen (14) calendar days from written notice for the parent or caregiver to demonstrate compliance. Upon suspension, CT ABA Services LLC will provide referrals to alternative ABA providers where available and will cooperate in transferring records upon written request.
4.3 Financial Obligations Following Suspension. Suspension does not relieve lawfully incurred financial obligations, including outstanding copayments, coinsurance, deductible amounts, and lawfully assessed late cancellation or no-show fees (private insurance and self-pay clients only). HUSKY Health and Medicaid clients will not owe any amount for covered services rendered or missed appointment fees.
4.4 Reinstatement. A parent or guardian may request reinstatement by: (a) submitting a written request; (b) resolving any lawful outstanding financial obligations; and (c) demonstrating a commitment to comply, which may include completing a parent training session before services resume. Reinstatement is subject to clinical review, staff availability, and insurance authorization. CT ABA Services LLC may decline reinstatement if the BCBA determines that treatment goals cannot be effectively achieved without adequate caregiver participation.

5. ACKNOWLEDGMENT AND AGREEMENT

By signing below, I acknowledge that I have read, understand, and agree to all terms of this Parent/Caregiver Participation and Attendance Agreement. I understand that:

l) My active participation in reinforcing behavioral strategies is a clinical requirement, not a suggestion.
m) Consistent attendance is essential to my child's treatment progress.
n) The twenty-four (24) hour cancellation notice requirement applies to me regardless of my coverage type.
o) If my child is a HUSKY Health or Medicaid member, I will not be charged any fee for missed appointments; however, all clinical consequences of excessive cancellations described in Section 2.4 apply to me fully.
p) Failure to comply with this agreement may result in suspension of services following written notice and an opportunity to correct as described in Section 4.
q) This agreement is a condition of continued enrollment in ABA services with CT ABA Services LLC.

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

CT ABA Services LLC Representative: _____

Title: _____ Date: _____

SECTION 6: AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (45 CFR 164.508)

(j) PARTY AUTHORIZED TO DISCLOSE: CT ABA Services LLC, 1000 Lafayette Blvd, Suite 1100, Bridgeport, CT 06604-4710.

(k) PARTY AUTHORIZED TO RECEIVE OR EXCHANGE: [ ] Exchange [ ] Release to [ ] Obtain from:
Name: _____ Title: _____
Organization: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

(l) INFORMATION TO BE DISCLOSED (check all that apply): [ ] Assessments [ ] Treatment Plans [ ] Behavior Intervention Plans [ ] Functional Behavior Assessments [ ] Educational Records [ ] Medical Records [ ] Clinical Records [ ] Insurance/Billing Records [ ] Discharge Summary [ ] Other: _____

(m) PURPOSE (check all that apply): [ ] Care Coordination [ ] Insurance Billing [ ] Educational Planning [ ] Legal Proceedings [ ] At Individual Request [ ] Other: _____

(n) METHOD OF DISCLOSURE: [ ] Verbal [ ] Written/Electronic [ ] Both

(o) EXPIRATION: This Authorization expires on _____ (date) or upon the following event: _____. If no date or event is specified, this Authorization expires two (2) years from the date of signature.

(p) RIGHT TO REVOKE: You may revoke this Authorization at any time by submitting a written request to CT ABA Services LLC. Revocation will not apply to information already disclosed in reliance on this Authorization.

(q) RE-DISCLOSURE WARNING: Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

(r) CONDITIONING: Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this Authorization.

(s) RIGHT TO A COPY: You are entitled to receive a copy of this signed Authorization.

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

If signed by a Personal Representative, state authority (e.g., legal guardian, power of attorney): _____

Witness Printed Name: _____ Witness Signature: _____ Date: _____

SECTION 7: AUTHORIZATION TO BILL INSURANCE AND ASSIGNMENT OF BENEFITS

Client Name: _____ Date of Birth: _____

Insurance Provider: _____

Policy Number: _____ Group Number: _____

Policyholder Name: _____ Policyholder Date of Birth: _____

Relationship to Client: _____

By signing below, I authorize CT ABA Services LLC to:

(t) Submit claims and billing statements to the above-identified insurance provider for Applied Behavior Analysis (ABA) services rendered to the Client.

(u) Release to the insurance provider any clinical or administrative information, including diagnosis codes, procedure codes, treatment records, and supporting documentation, as necessary to process claims, obtain prior authorizations, and facilitate payment.

(v) Receive payment of benefits directly from the insurance provider on my behalf. I hereby assign all insurance benefits payable for services provided by CT ABA Services LLC directly to CT ABA Services LLC.

I understand and agree to the following:

(w) I am financially responsible for all copayments, coinsurance, deductibles, non-covered services, and any balance not paid by my insurance provider.

(x) Verification of insurance benefits is not a guarantee of payment. I remain responsible for any amounts my insurer declines to pay, including denied claims.

(y) I will maintain active insurance coverage throughout the course of services and will notify CT ABA Services LLC within five (5) business days of any change in insurance status, coverage, or policyholder information.

(z) If a claim is denied, CT ABA Services LLC will make reasonable efforts to appeal; however, I remain responsible for the balance if the denial is upheld.

(aa) This authorization remains in effect for the duration of the Client's enrollment with CT ABA Services LLC or until revoked by me in writing.

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

SECTION 8: FINANCIAL RESPONSIBILITY AGREEMENT

1. COVERAGE TYPE IDENTIFICATION

Client Name: _____ Date of Birth: _____

Complete the following with CT ABA Services LLC staff. Check the coverage type that applies:
[ ] HUSKY HEALTH / MEDICAID: Sections 2 and 6 apply to you. Sections 3, 4, and 5 DO NOT apply to you.
[ ] PRIVATE / COMMERCIAL INSURANCE: Sections 3, 4, 5, and 6 apply to you.
[ ] SELF-PAY (no insurance, or insurance not used): Sections 4, 5, and 6 apply to you.
Coverage type verified by (staff): _____ Date: _____

2. HUSKY HEALTH AND MEDICAID CLIENTS: YOUR PROTECTIONS

If you or your child are enrolled in HUSKY Health or Medicaid, federal and Connecticut law (42 CFR § 447.15; CMAP Provider Bulletin PB 2015-05) protect you as follows:

- CT ABA Services LLC accepts HUSKY Health/Medicaid payment as PAYMENT IN FULL for covered ABA services.
- You will NOT be charged copayments, coinsurance, or deductibles for covered services.
- You will NOT be charged for missed, late-cancelled, or no-show appointments.
- You will NOT be balance billed for any amount above what HUSKY Health/Medicaid pays.
- You will NOT be asked to place a deposit or keep a credit card on file as a condition of receiving services.

You may owe money to CT ABA Services LLC only in two narrow circumstances:

a) You affirmatively decline a specific service in writing that HUSKY Health/Medicaid does not cover, and you agree in writing, in advance, to pay for it privately.

b) Your HUSKY Health/Medicaid eligibility ends, and you receive services on dates after your coverage ended. We will make every reasonable effort to verify your eligibility before each authorization period and to notify you promptly if we learn your coverage has lapsed.

If you are ever charged in violation of these protections, contact us immediately at (203) 906-5328. The charge will be refunded promptly. You may also contact the Connecticut Behavioral Health Partnership at (877) 552-8247 or the Connecticut Department of Social Services at (855) 626-6632.

Attendance Expectations: While we cannot charge you a fee for missed appointments, consistent attendance remains essential to your child's progress and to maintaining insurance authorization. Excessive cancellations will trigger a clinical review of the service schedule as described in the Parent/Caregiver Participation and Attendance Agreement, and may affect the number of authorized hours HUSKY Health approves.

3. INSURANCE BILLING AND COST-SHARING (PRIVATE AND COMMERCIAL INSURANCE CLIENTS)

This Section 3 applies only to clients with private or commercial insurance coverage as identified in Section 1.

c) CT ABA Services LLC will verify insurance benefits and obtain required prior authorizations before commencing services when possible. Verification of benefits is not a guarantee of payment.

d) CT ABA Services LLC will submit claims to your insurance carrier on your behalf.

e) You are responsible for maintaining active insurance coverage and notifying CT ABA Services LLC immediately of any change to your insurance information, including carrier, policy number, group number, or policyholder status.
f) If your insurance requires a referral or prior authorization and one is not obtained, you may be responsible for the full cost of services rendered.

COPAYMENTS, DEDUCTIBLES, AND COINSURANCE:

g) Copayments, coinsurance, and deductible amounts are due within fifteen (15) days of billing.
h) You are responsible for all amounts your insurance plan assigns to you.
i) CT ABA Services LLC will provide statements detailing amounts owed.

DENIED CLAIMS AND APPEALS:

j) If your carrier denies a claim, CT ABA Services LLC will make reasonable efforts to appeal on your behalf.
k) If the denial is upheld after all appeals are exhausted, you will be responsible for the cost of services rendered.
l) CT ABA Services LLC will notify you of any denied claim and the outcome of each appeal.

4. SELF-PAY CLIENTS AND GOOD FAITH ESTIMATE

If you do not have insurance coverage, or you elect not to use your insurance, you are responsible for the full cost of services rendered by CT ABA Services LLC.

m) Before services begin, CT ABA Services LLC will provide you with a written Good Faith Estimate of expected charges as required under the federal No Surprises Act (45 CFR § 149.610). The Good Faith Estimate will itemize expected services, service codes, and expected charges.
n) You have the right to initiate a patient-provider dispute resolution process if your actual billed charges exceed your Good Faith Estimate by $400 or more.
o) Payment for self-pay services is due within fifteen (15) days of billing unless a written payment plan has been arranged in advance with CT ABA Services LLC.
p) If you have questions about your Good Faith Estimate or wish to arrange a payment plan, contact our billing office at (203) 906-5328 or TJG@CTABASERVICES.COM.

5. CANCELLATION AND NO-SHOW POLICY (PRIVATE INSURANCE AND SELF-PAY CLIENTS ONLY)

This Section does not apply to HUSKY Health/Medicaid clients. If your coverage type is HUSKY Health/Medicaid as identified in Section 1, see Section 2 for your applicable protections.

q) You must provide at least twenty-four (24) hours' notice to cancel a scheduled session. This is a strict requirement.
r) Late cancellations (less than 24 hours' notice) and no-shows are subject to a fee of $50.00 per occurrence.
s) If the client is not available within fifteen (15) minutes of the scheduled start time without prior notice, the session may be recorded as a no-show.
t) Three (3) or more cancellations within a sixty (60)-day period will trigger a mandatory review of the service schedule and may affect insurance authorization.
u) Excessive cancellations may result in reduced authorized hours, a modified schedule, or suspension of services as described in the Parent/Caregiver Participation and Attendance Agreement.

6. GENERAL PROVISIONS AND ACKNOWLEDGMENT

6.1 BILLING STATEMENTS AND DISPUTES: Direct questions or disputes regarding any charge to the billing office within thirty (30) days of receiving the statement. Billing Office: (203) 906-5328 or TJG@CTABASERVICES.COM. CT ABA Services LLC will investigate and respond in writing.

6.2 NO SURCHARGE: CT ABA Services LLC does not impose any surcharge, processing fee, or convenience fee based on method of payment, consistent with Conn. Gen. Stat. Section 42-133ff.

6.3 COLLECTIONS (Private Insurance and Self-Pay Clients Only): Accounts with balances more than thirty (30) days past due may be referred to a collections agency. You may be responsible for collection costs actually incurred. CT ABA Services LLC will attempt to contact you and offer a payment plan before any referral. HUSKY Health/Medicaid clients will not be referred to collections for covered services.

6.4 PAYMENT PLANS: If you are unable to pay a balance in full, contact the billing office. CT ABA Services LLC will work with you in good faith to establish a reasonable payment plan.

6.5 CONTINUITY OF ACTIVE TREATMENT: CT ABA Services LLC will not discontinue an active course of treatment solely because of an unpaid balance without first providing written notice, offering a payment plan, and allowing a reasonable opportunity to resolve the balance.

ACKNOWLEDGMENT: By signing below, I acknowledge that I have read, understand, and agree to the financial policies of CT ABA Services LLC that apply to my coverage type as identified in Section 1

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

SECTION 9: CLIENT RIGHTS AND RESPONSIBILITIES

CT ABA Services LLC is committed to protecting the rights of every Client and family we serve. By enrolling in services, you acknowledge the following rights and accept the following responsibilities.

1. CLIENT RIGHTS

As a Client of CT ABA Services LLC, you have the right to:

(bb) Receive services in a safe, clean, and therapeutic environment.

(cc) Be treated with dignity, respect, and freedom from discrimination based on race, color, national origin, age, disability, sex, religion, or any other protected characteristic.

(dd) Privacy and confidentiality of all personal and health information in accordance with HIPAA and Connecticut state law.

(ee) Receive clear information about your treatment plan, goals, and progress.

(ff) Participate actively in treatment planning and decision-making.

(gg) Refuse any treatment or procedure at any time.

(hh) Request and receive information regarding provider credentials and qualifications.

(ii) Access, inspect, and obtain copies of your clinical records.

(jj) File a grievance or complaint without fear of retaliation or reduction in services.

(kk) Freedom from abuse, neglect, and exploitation.

(ll) Reasonable accommodations for language, communication, or disability needs.

(mm) Receive information about the cost of services before treatment begins.

(nn) Receive a copy of the Notice of Privacy Practices (Section 3).

(oo) Withdraw from services at any time upon written notice.

(pp) Be informed of any changes to services, policies, or reasons for discontinuation.

2. CLIENT AND PARENT/GUARDIAN RESPONSIBILITIES

As a client or Parent/Guardian, you agree to:

(qq) Provide accurate and complete information on all intake and clinical forms.

(rr) Follow the individualized treatment plan as developed by the clinical team.

(ss) Attend all scheduled appointments consistently.

(tt) Participate in parent/caregiver training sessions as required by Section 5 of this packet.

(uu) Communicate concerns, changes in condition, or barriers to treatment promptly.

(vv) Maintain a safe environment for all sessions conducted in the home or community.

(ww) Treat all CT ABA Services LLC staff with courtesy and respect.

(xx) Provide at least 24 hours advance notice for any cancellation.

(yy) Notify CT ABA Services LLC promptly of any changes to insurance coverage.

(zz) Make timely payment of all copays, coinsurance, deductibles, and fees as outlined in the Financial Responsibility Agreement (Section 8).

(aaa) Notify CT ABA Services LLC of any changes in custody or legal guardianship.

(bbb) Follow all safety guidelines and protocols communicated by the clinical team.

ACKNOWLEDGMENT

I have read and understand the Client Rights and Responsibilities set forth above. I agree to fulfill the responsibilities described herein as a condition of receiving services from CT ABA Services LLC.

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

SECTION 10: PHOTO AND MEDIA RELEASE (OPTIONAL)

Client Name: _____ Date of Birth: _____

CT ABA Services LLC requests your permission to use photographs, videos, or other media of the above-named Client for the purposes identified below. This release is entirely optional and will not affect the Client's eligibility for or receipt of services.

1. GRANT OR DENIAL OF PERMISSION

[ ] I GRANT permission to CT ABA Services LLC to use photographs or media of my child for the following purposes (check all that apply):

- [ ] Website
- [ ] Social media
- [ ] Print materials
- [ ] Training materials
- [ ] Conferences or presentations
- [ ] Other: _____

[ ] I DO NOT GRANT permission to CT ABA Services LLC to use photographs or media of my child for any purpose.

2. TERMS AND CONDITIONS

(ccc) This release is voluntary. Refusal will have no effect on the quality or availability of services.

(ddd) Only the Client's first name may be used. No last name, diagnosis, or Protected Health Information will be disclosed without a separate HIPAA-compliant authorization.

(eee) No compensation will be provided for the use of any photographs or media.

(fff) This release may be revoked at any time by submitting a written request to CT ABA Services LLC. Revocation will not apply retroactively to materials already published or distributed prior to receipt of the revocation.

3. SPECIAL INSTRUCTIONS:

_____

4. SIGNATURE

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

SECTION 11: GRIEVANCE AND COMPLAINT PROCEDURE

CT ABA Services LLC is committed to resolving concerns promptly and fairly. Clients and their families may file a grievance or complaint at any time without fear of retaliation or adverse effect on services.

1. INTERNAL COMPLAINT PROCESS

Step 1: Contact the assigned BCBA directly to discuss the concern. Many issues can be resolved at this level.

Step 2: If the matter is not resolved, submit a complaint to Celina Bustamante, Chief Officer of Operations, at (475) 439-2530 or cb@ctabaservices.com. Include: client name, description of the concern, relevant dates, steps already taken, and desired outcome. Written complaints are preferred. CT ABA Services LLC will acknowledge receipt within five (5) business days and complete an investigation within thirty (30) calendar days. A written outcome will be provided.

Step 3: If the outcome remains unsatisfactory, the matter may be escalated to CEO Babatunde "TJ" Green at (203) 906-5328 or TJG@CTABASERVICES.COM.

2. NON-RETALIATION POLICY

No client or family member will be subject to retaliation, discrimination, or reduction in services for filing a complaint.

3. EXTERNAL COMPLAINT RESOURCES

Agency	Phone	Website or Email
Connecticut Department of Public Health (DPH)	(860) 509-7400	
U.S. Department of Health and Human Services, Office for Civil Rights (HHS OCR)	(800) 368-1019	OCRComplaint@hhs.gov
Behavior Analyst Certification Board (BACB)		www.bacb.com
CT Department of Social Services / HUSKY Health	(855) 626-6632	
Connecticut Healthcare Advocate	(866) 466-4446	

ACKNOWLEDGMENT

I acknowledge that I have received and reviewed the Grievance and Complaint Procedure of CT ABA Services LLC.

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

SECTION 12: NOTICE REGARDING RETENTION OF MEDICAL RECORDS

CT ABA Services LLC maintains client records in accordance with Connecticut law. This notice explains our retention policy and the process for requesting copies of your records.

1. RETENTION PERIOD

CT ABA Services LLC retains all client medical and clinical records for a minimum of seven (7) years from the date of the last service provided, or until the client reaches the age of majority plus seven (7) years, whichever is later.

2. REQUESTING COPIES OF RECORDS

You have the right to request copies of your records at any time. All requests must be submitted in writing to:

CT ABA Services LLC, Attn: Records Request, 1000 Lafayette Blvd, Suite 1100, Bridgeport, CT 06604-4710

Each written request must include: (a) the client's full name and date of birth; (b) a description of the records requested; (c) the applicable time; and (d) your preferred delivery method (mail, electronic, or in-person pickup).

CT ABA Services LLC will respond to all records requests within thirty (30) calendar days of receipt. Records will be provided in the format requested when reasonably available. A reasonable fee may be charged for copying and delivery costs.

3. QUESTIONS

For questions regarding records retention or requests, please contact: Celina Bustamante, Chief Officer of Operations, Phone: (475) 439-2530, Email: cb@ctabaservices.com.

ACKNOWLEDGMENT

I acknowledge that I have read and understand this Notice Regarding Retention of Medical Records.

Field	***Entry***
Parent/Guardian Printed Name	_____
Parent/Guardian Signature	_____
Date	_____

PAYMENT AUTHORIZATION AND CREDIT CARD ON FILE AGREEMENT

1. CLIENT AND CARDHOLDER INFORMATION

CT ABA Services LLC
1000 Lafayette Blvd, Suite 1100
Bridgeport, CT 06604-4710
Phone: (203) 906-5328 | Email: TJG@CTABASERVICES.COM

PAYMENT AUTHORIZATION AND CREDIT CARD ON FILE AGREEMENT

CLIENT INFORMATION

Field	
Client Name:	_____
Date of Birth:	_____
Parent/Guardian Name:	_____
Phone:	_____ Work:_____

COVERAGE AND BILLING CLASSIFICATION (For Office Use)
Check the applicable coverage type for this client. This classification determines which payment authorization categories apply.

[ ] OPTION A: HUSKY Health / Medicaid (Fully Covered)

Client is enrolled in Connecticut HUSKY Health or Medicaid. Covered services have no copayment, coinsurance, or deductible. Payment method on file applies only to: late cancellation and no-show fees, services not covered by HUSKY Health/Medicaid, and any balance resulting from loss of HUSKY Health/Medicaid eligibility.

[ ] OPTION B: Private Insurance (Partial Billing)

Client has private or commercial insurance. Client is responsible for copayments, coinsurance, and deductible amounts as determined by the insurance plan. Payment method on file applies to: copayments and coinsurance, deductible amounts, outstanding balances from denied or non-covered claims, and late cancellation and no-show fees.

[ ] OPTION C: Self-Pay (No Insurance)

Client does not have insurance coverage or has elected not to use insurance. Client is responsible for the full cost of all services at the rates provided by CT ABA Services LLC. A Good Faith Estimate of charges will be provided prior to the

start of services as required under the No Surprises Act. Payment method on file applies to: all service charges, and late cancellation and no-show fees.

Classification completed by (Staff Name): _____ Date: _____

Insurance Carrier (if applicable): _____ Policy Number: _____
Group Number: _____

HUSKY Health / Medicaid ID (if applicable): _____

CARDHOLDER INFORMATION

Field	
Cardholder Name (as it appears on card):	_____
Billing Address:	_____
City:	_____
State:	____
Zip Code:	_____
Phone:	_____ Work:_____
Email:	_____

PAYMENT METHOD (check one):

- [ ] Credit Card
- [ ] Debit Card
- [ ] HSA / FSA Card
- [ ] ACH / Bank Transfer (attach voided check or provide routing and account information below)

CARD INFORMATION

Field	
Card Number:	_____
Expiration Date:	_____ / _____
CVV/Security Code:	_____

ACH / BANK TRANSFER INFORMATION (if applicable)

Field	
Bank Name:	_____
Routing Number:	_____
Account Number:	_____
Account Type:	[ ] Checking [ ] Savings

2. GRANT OF PAYMENT AUTHORIZATION AND AUTHORIZED CHARGES

I, the undersigned, hereby authorize CT ABA Services LLC to charge the payment method identified above for amounts owed in connection with Applied Behavior Analysis (ABA) and related services provided to the above-named Client. The applicable charges depend on the Coverage and Billing Classification selected above (Option A, B, or C). This authorization applies to the following categories of charges:

AUTHORIZED CHARGES (check all that apply):

[ ] Copayments and Coinsurance (Option B only): I authorize CT ABA Services LLC to charge my payment method on file for insurance copayments and coinsurance amounts due after each session, as determined by my insurance plan. The copayment or coinsurance amount is established by my insurance carrier and may change if my insurance plan changes.

[ ] Deductible Amounts (Option B only): I authorize CT ABA Services LLC to charge my payment method on file for deductible amounts owed, as determined by my insurance carrier.

[ ] Outstanding Balances (Options A, B, and C): I authorize CT ABA Services LLC to charge my payment method on file for any outstanding balances resulting from services already rendered, including amounts not covered by insurance, denied claims (after the appeals process has been exhausted), balances resulting from loss of insurance eligibility, self-pay service charges, and any other balance due in accordance with the Financial Responsibility Agreement.

[ ] Late Cancellation and No-Show Fees (Options A, B, and C): I authorize CT ABA Services LLC to charge my payment method on file for late cancellation fees (less than 24 hours' notice) and no-show fees in the amount of $50.00 per occurrence, as outlined in the Parent/Caregiver Participation and Attendance Agreement and the Financial Responsibility Agreement.

[ ] Self-Pay Service Charges (Option C only): I authorize CT ABA Services LLC to charge my payment method on file for the full cost of all ABA and related services at the rates provided to me by CT ABA Services LLC prior to the start of services.

[ ] Other Fees or Charges (specify): _____

3. RECURRING PAYMENT AUTHORIZATION

I understand and agree that this authorization permits CT ABA Services LLC to process charges to the payment method on file on a recurring basis without requiring my signature for each individual transaction. Charges will be processed as follows:

(a) Copayments and coinsurance will be charged within seven (7) business days following each session.

(b) Deductible amounts will be charged as they become due based on insurance plan processing.

(c) Outstanding balances will be charged after a billing statement has been issued and the fifteen (15)-day payment window has elapsed.

(d) Late cancellation and no-show fees will be charged within seven (7) business days following the missed or late-cancelled appointment.

I will receive an email notification and/or receipt for each charge processed to my payment method. If I believe a charge is incorrect, I may contact the CT ABA Services LLC billing office at (203) 906-5328 or TJG@CTABASERVICES.COM within thirty (30) days of the charge to dispute it.

4. TERMS AND CONDITIONS

(e) Duration. This authorization remains in effect for the duration of the Client's enrollment in services with CT ABA Services LLC, or until revoked in writing by the undersigned, whichever occurs first.

(f) Revocation. The undersigned may revoke this authorization at any time by providing written notice to CT ABA Services LLC at 1000 Lafayette Blvd, Suite 1100, Bridgeport, CT 06604-4710, or by email to TJG@CTABASERVICES.COM. Revocation will take effect within five (5) business days of receipt and does not affect charges already processed or amounts incurred prior to the effective date of revocation.

(g) Updated Payment Information. The undersigned agrees to notify CT ABA Services LLC promptly if the payment method on file changes, expires, or is cancelled, and to provide updated payment information. If a payment method is declined, CT ABA Services LLC will notify the undersigned, who agrees to provide an alternative payment method within ten (10) business days.

(h) Declined Transactions. If a charge is declined, CT ABA Services LLC will attempt to process the charge one (1) additional time within five (5) business days. If the second attempt is also declined, CT ABA Services LLC will contact the undersigned to arrange alternative payment. Repeated declined transactions may result in a requirement to pay by alternative means before each session.

(i) Financial Obligation. This payment authorization does not alter or replace any financial obligations under the Financial Responsibility Agreement. All terms of the Financial Responsibility Agreement remain in full force and effect.

(j) Security. CT ABA Services LLC will store payment information securely in compliance with Payment Card Industry Data Security Standards (PCI-DSS). Card information will not be shared with any third party except as necessary to process authorized charges.

(k) Refunds. If the undersigned is overcharged or if a charge is processed in error, CT ABA Services LLC will issue a refund to the original payment method within fourteen (14) business days of discovering or being notified of the error.

(l) Online Payment Portal. CT ABA Services LLC may offer an online payment portal as an alternative to the card-on-file arrangement. If available, the undersigned may use the online portal to make one-time payments at any time. Use of the online portal does not affect the terms of this recurring authorization unless this authorization is revoked in writing.

5. GRANT STATEMENT AND ACKNOWLEDGMENTS

By signing below, I grant CT ABA Services LLC full permission and authority to charge the payment method identified above for the categories of charges I have selected. I acknowledge that I have read and understand the terms of this Payment Authorization and Credit Card on File Agreement. I understand that:

- I am authorizing recurring charges to my payment method without requiring a separate signature for each individual transaction.
- I will receive a notification and/or receipt for each charge processed.
- I may revoke this authorization at any time in writing, but revocation does not relieve me of financial obligations already incurred.
- My payment information will be stored securely in compliance with PCI-DSS.
- This authorization is voluntary; however, if I choose not to keep a payment method on file, I will be required to make payment by other means within the timeframes specified in the Financial Responsibility Agreement.

6. SIGNATURES AND OFFICE USE

SIGNATURES

Field	Entry
Cardholder Printed Name	_____
Cardholder Signature	_____
Date	_____

If the cardholder is someone other than the Parent/Guardian:

Field	Entry
Parent/Guardian Printed Name	_____
Parent/Guardian Signature	_____
Date	_____

Relationship to Client	_____

FOR OFFICE USE ONLY

Field	Entry
Payment method verified by	_____
Date	_____
Card last four digits	_____
Expiration	_____ / _____
Payment method entered into system	[ ] Yes Date: _____
Staff Initials	_____