DOCUMENTS NEEDED TO PROVIDE SERVICES

Please we will need to see the original documents and we will make the copies at the office.

Por favor, necesitaremos ver los documentos originales y haremos las copias en la oficina.

ID CARD OF PARENT/LEGAL GUARDIAN / IDENTIFICACIN OFICIAL DEL PADRE

INSURANCE CARD (CHILD) / TARJETA DE SEGURO (DEL NIÑO)

IEP (THE IEP, INDIVIDUALIZED EDUCATION PROGRAM, IS A WRITTEN DOCUMENT THAT'S DEVELOPED FOR EACH PUBLIC SCHOOL CHILD WHO IS ELIGIBLE FOR SPECIAL EDUCATION), MEDICAL EVALUATIONS, DR'S OFFICE NOTES/ EVALUACIONES MEDICAS O NOTAS DE OFICINA IF YOU HAVE A BEHAVIORAL/ THERAPY EVALUATION OR ASSESSMENT ON THE LAST 6 MONTHS BRING IT TO US

I ____agree to send or email a copy of the documents listed above.

- **Child's Preferred Language for Oral and Written communications**
- **Idioma preferido del niño para las comunicaciones orales y escritas**
- **Langue préférée de l'enfant pour les communications orales et écrites**
- **Lingua preferita del bambino per le comunicazioni orali e scritte**

儿童口头和书面交流的首选语言

____ ________________________

Parent/Legal Guardian Signature **Date**

700 South Main Street. LaBelle, FL 33935
info@kidstherapysolutions.com

CONSENT FOR TREATMENT OF MINORS

This is to certify that the information on the intake forms is accurate to the best of my knowledge.

I give permission to Kids Therapy Solutions Corp to assess and provide treatment for my child. I verify that all legal guardians are aware of and give consent for this treatment as well.

Printed Name of Parent/Guardian: ________________________ Relationship to Patient: ____________

Signature of Parent/Guardian: _____________________________________ Date: _______________

Patient Name:____ DOB:_______________________

Please **initial** the following statements:

______ I hereby give Kids Therapy Solutions Corp permission to evaluate and treat my child, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and Kids Therapy Solutions Corp staff.

______ I understand that state representatives for insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

NEW PATIENT INTAKE FORM

Child's Legal Name: ______________________________________ Date of Birth: __________________

Age: _________________ Male: _____ Female: _____ **Legal Guardian**: _________________________

Primary Care/Pediatrician: ______________________

Can we leave a message: **Yes No**

Home Number: ____________________________

Cell Number: ______________________________

Work Number: _____________________________

Best number to reach you on: ________________________

Email: ____ Physical Address: _____________________

City, State, Zip: _________________________________

Mailing Address, if different from physical address: ____

City, State, Zip: __________________________________

Child's diagnoses and physician who provided initial diagnosis:

____

Who referred you to our office?

____

INSURANCE INFORMATION (Please fill out ALL areas)

Primary Insurance: _______________________________ Secondary Insurance: ___________________

Policy Number: __________________________________ Policy Number: ________________________

Group Number: __________________________________ Group Number: _______________________

Insured's Name: _________________________________ Insured's Name: _______________________

Insured's DOB: __________________________________ Insured's DOB: _______________________

Please **initial** the following statement:

_______ **I DO NOT HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAN THE ABOVE MENTIONED.**

TECHNOLOGY PERMISSION

Please **initial** the following OPTIONAL statements:

______ EMAIL: I give permission to Kids Therapy Solutions Corp to correspond with my child's legal guardians and care team via e-mail regarding treatment, documentation, and home programming. I understand that email is encrypted internally; however, once an email is sent externally, correspondence may potentially be intercepted by an outside party.

______ TEXT: I authorize Kids Therapy Solutions Corp to send text messages to my cell phone related to my child's therapy. I understand that standard data and text messaging rates will apply to any messages received from. I agree not to hold Kids Therapy Solutions Corp liable for any electronic messaging charges or fees generated by this service. I also understand that I may opt out at any time via text (replying "STOP" at any time) or by alerting the front desk. If my cell phone number changes, I will inform the front desk/Clinic manager.

I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution, to release all of medical information by any means of communication to Kids Therapy Solutions Corp.

_________________________________ _________________________

Parent/Legal Guardian Signature **Date**

Please check all that apply:

☐ **Elopements** ☐ **Pica** ☐ **Climbing** ☐ **Biting self or others** ☐ **Head slapping/hitting self or others**

☐ **Head banging** ☐ **Refusal to comply** ☐ **Property destruction** ☐ **Throwing objects**

☐ **Tantrums** ☐ **Bolting running away from instruction or activity but remaining in safe area**

☐ **Difficulty with expressive language** ☐ **Difficulty with receptive language** ☐ **Non-verbal communication** ☐ **Hyperactivity** ☐ **Impulsivity** ☐ **Spitting, wiping saliva** ☐ **Lying**

Other:
____

_________________________________ _________________________

Parent/Legal Guardian Signature **Date**

Social History & Living Situation

Please describe your child's living situation (and any recent changes):

____

Siblings' names and ages:

____ If your child was adopted, please answer the following questions:

Age of adoption: ________ Is your child aware of adoption? YES NO Previous home experiences prior to adoption:

____

____

Educational History

Grade: ______ Name of school: _____________________________ Teacher: __________________

What kind of classroom (e.g., regular ed, special ed, life skills, hospital homebound, homeschool, etc.):

____

Does your child have an IEP, 504 Plan, accommodations? YES NO

What services does your child receive at school? ______________________________ Names of any school therapists?

____

Personal Information

Please describe your child's personality:

____

____

List the names of the programs and people that have worked or are working with your child outside of Kids Therapy Solutions Corp

****If your child has an IEP through his/her school, please bring us a copy for our records. ****

****If your child has any additional testing, please bring us a copy for our records. ****

Service	Practice/School Name	Provider Name	Last Seen/Frequency
Pediatrician/Physician			
Child Care Program			
Preschool			
School			
Occupational Therapist			
Speech Therapist			
Physical Therapist			
Counselor/Psychologist			
Infant Learning Program			
Head Start Program			
Caseworker/Care Coordinator			
Dietitian/Nutritionist			
Specialty Doctor			
Other			

Please provide detail regarding the concerns of your child's development, if any.

___

Please provide any problems or interfering behaviors of concern

___

Please state the expectations/goals that you have for your child while engaging in a behavioral program

___

Medical History

Please describe illnesses, hospitalizations, or surgeries that your child has had and when they occurred:

___

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for Kids Therapy Solutions Corp to provide ABA services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

____ _________________________

Parent/Legal Guardian Signature **Date**

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are willing to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our financial policy.

Payment, co-payment, deductibles, and co-insurance for services are due each visit for charges incurred up through your last visit. We accept cash, checks, VISA, MasterCard, and Discover Card. **Please understand that you are financially responsible for all charges, whether they are paid by insurance.**

Please read carefully:

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. As a courtesy to our patients, we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason any portion of a bill is not paid by your insurance within 60 days from the date of service, you agree to plan for prompt payment.
2. Should your insurance coverage change, our office should be notified within 30 days of the effective date and the card or stickers should be available for copying. If you fail to provide us this information, your account and all future balances will be your responsibility. We will no longer bill insurance and you will be responsible for submitting claims to your insurance. Payment will also be due at the time of service in full.
3. Any returned checks will be subject to an NSF fee of $25.00 which will be due at the next visit.

4. Once the BCBA (analyst) has visited the client and done the interview to start the assessment process. If the parent decides to apply for another company or cancel ABA services, and the analyst has already started the assessment process. Caregivers or signing legal guardian will be responsible for paying for the services at full analyst rate 75$ hourly.

Please **initial** the following statements:

______ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the

necessary information regarding limits of coverage, co-pays, and co-insurance.
______ I give Kids Therapy Solutions Corp permission to submit bills directly to the insurance carrier.

I hereby understand the above financial policy and agree to abide by it.

____ _________________________

Parent/Legal Guardian Signature **Date**

EMERGENCY MEDICAL RELEASE

In the event medical attention is required for your child while in the premises of Kids Therapy Solutions Corp, we need your authorization to implement treatment. Please read and sign statement below.

As legal guardian of ____________________________, I give my permission for Kids Therapy Solutions Corp to contact emergency personnel in the event of a medical emergency.

_______________________________________ ___________________________ **Parent/Legal Guardian Signature** **Date**

EMERGENCY CONTACT

NAME: ____ PHONE: ____________________________

RELATIONSHIP: ____

MEDICATION/ALLERGIES/CONDITIONS

Medications (Include prescription drugs, over the counter meds, vitamins, and homeopathic medications):

____

______________________, ______________________, _________________________, ______________________, ______________________

Allergies/Reactions:

____

Diagnoses (Any known medical diagnosis or medical condition, with dates of diagnosis if known):

____

Does your child require an Epi Pen: **Yes No**

I, ___________________________________ state that the above is true and complete to the best of my knowledge, I authorize Kids Therapy Solutions Corp to provide food items fitting within the parameters above to my child for behavior reinforcers. If applicable, I authorize Kids Therapy Solutions Corp to administer the Epi Pen that I have provided for my child in the event of an anaphylactic emergency. I understand that by signing this form I am releasing Kids Therapy Solutions Corp of any liability herein.

Parent Signature: ____________________________________ Date: ________________________

PHOTO PERMISSION
Please **initial** the following OPTIONAL statements:

______ I give permission for photos/videos of my child to be used for the purposes of treatment, education, and documentation.

PATIENT AGREEMENT

Kids Therapy Solutions Corp offers ABA therapy services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your child's therapy needs.

Following the initial assessment visit. We are pleased to serve your ABA needs and encourage your feedback to alert us to anything we can do to provide your child with the highest quality of care.

We require certain information from each patient to begin providing care. The attached forms need to be completed for us to begin serving your child as our patient. Please do your best to complete all the information. If certain information does not apply to your child, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payor has different guidelines for allowing coverage of ABA services. It is helpful if you let us know your healthcare payor when starting service so that we may find out if prior authorizations are needed. If your child is a Medicaid beneficiary, please ask your primary care provider to send us a referral for your initial assessment to fulfill Medicaid requirements. If your healthcare insurance payor does not cover ABA services, you are welcome to make self-pay arrangements for the usual and customary pricing of our services.

PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICE

Private insurance companies may have limits on the amount of ABA covered. Once you have exceeded the financial limit of your benefits and you do not have additional healthcare coverage, you are responsible for the payment of your child's services. Additionally, private healthcare insurance payors have deductible and co-payments for ABA services that are the responsibility of the patient.

While this practice will not discontinue your child's services for financial hardships, it is expected that patients pay at the time of service and/or set up payment arrangements. *Please see attached patient payment policy and credit card authorization form

PRIVATE PAY

Payment is due at the time of service. Once a year your child will receive a reassessment to update current plan and review progress. This requires an additional fee; our clinic manager will schedule date and time for the reassessment and discuss payment and fee associated.

COLLECTION OF PAST DUE ACCOUNTS

We communicate with our patients' parents/guardians to resolve past due accounts in all cases. If we cannot reach a patient's parent/guardian by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your child's caregiver experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either in writing or by phone at (239) 544-8602. A member of our management team will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

KIDS THERAPY SOLUTIONS CORP SCOPE OF PRACTICE

Medical Acuity & Medical Stability:
Children must be healthy and cleared for treatment by their physician. Children may not receive services if they have illnesses such as: fever of 100.5 or greater; pink eye; vomiting and/or diarrhea; or other highly contagious viruses and/or diseases.

Admission Criteria:
Children who experience delays, or are at significant risk for delays, in any area of development which negatively affects his/her functional performance and ability to participate in home, community and school activities. Children from 2 through 18 years of age will be considered for evaluation. Children 16 years and older may be seen on a case-by-case basis if he/she has lost a skill due to an accident or illness.

- Financial responsibility is established in accordance with the Financial Policy.
- An evaluation is completed which identifies the need for intervention.
- Additional factors considered before admission include areas of expertise of therapy staff and availability of appropriate treatment materials and equipment. If a client would benefit from treatment but is not approved for services due to the factors previously identified, he/she may be referred to other agencies that can provide needed services.

Discharge Criteria:
It is our policy to discharge clients who meet any of the following criteria are 18 years of age; no longer demonstrate need for intervention; do not appear to benefit from continued services; are not meeting financial responsibilities; do not meet the required attendance; are removed at the request of the caregiver; or are removed at the discretion of the agency (including for safety reasons).

• No Longer Demonstrates Need:
If a child has demonstrated sufficient progress in therapy and testing reveals the child's skills are at age-appropriate levels (i.e., no further intervention is indicated), the therapist will review the child's progress with the parent/caregiver and plan a discharge date.

• Does Not Appear to Benefit:
Progress in therapy is reviewed on a continuous basis. If a client does not meet therapy goals and/or does not demonstrate progress on re-evaluation after six months in therapy, the treating therapist will discuss the lack of progress and the treatment plan with their clinical supervisor and the child's caregiver. They may revise the treatment plan to better fit the child's needs at any time.

If a client does not meet therapy goals and/or does not demonstrate progress on a re-evaluation during the second six-month treatment period, the treating therapist will discuss the treatment plan with their clinical supervisor and the child's caregiver. An interdisciplinary team review shall be initiated. This discussion will include the possibility of revising the treatment plan, increasing, or decreasing the frequency of sessions, and discharge if no progress continues to be noted.

At the end of 18 months of treatment, if no progress has been noted and the above steps were taken, the client may be discharged.

- **Financial Responsibility:**

If a family is not meeting financial responsibilities to the agency as outlined in the Financial Policy, the client may be discharged from therapy.

- **Poor Attendance:**
  Poor attendees may be discharged per the Attendance Policy.
- **Parent/caregiver Request:**
  Discharge will be completed upon caregiver request.

- **<u>Agency Discretion:</u>**
  The agency reserves the right to discharge any client at any time for any reason.

<u>Changing Therapists</u>

A child may, at one time or another, experience a change in his or her therapist. This may happen for any one of the following reasons:

- Therapist relocation
- Therapist illness or family emergency
- Scheduling issues in which the family requests a different day of the week or time of day for ongoing
- therapy sessions. We will accommodate changes as they arise; however, this will occasionally result in the child switching therapists.
- Lack of progress or 'connection' with the child's assigned therapist. Our number one goal is for the child to receive a maximum benefit from therapy. Occasionally, a child has a personality conflict with the assigned therapist or just does not develop a good working relationship with the assigned therapist. In cases like this, it is in the best interest of the child to re-assign them to a different therapist. Additionally, the child or therapist may reach a point where the child still needs therapy but is failing to make acceptable progress. The change to a new therapist may assist the child to begin making progress once again. Change in the specific therapist's schedule.
- We make every effort to maintain continuity of care with as few changes as possible. When changes do arise, we will assist families in making the transition as smooth as possible.

Evaluation and Intervention:
Therapeutic evaluation and intervention are provided by state licensed and appropriately credentialed BCBA. Registered Behavior Therapist (RBT) provide services under the supervision of our BCBA's. In a collaborative process with the child and his/her parent/Guardian, outcomes for therapeutic intervention are created and reassessed every 6 months to determine frequency and duration of service.

As your team, you can expect us to:

1. Begin and end your appointments in a timely manner.
2. Inform you of the goals targeted and the progress made during each session.
3. Provide strategies and ways for you to address goals at home to increase carryover.
4. Provide parent training
5. Assist you in any way we can, from brainstorming ideas to help make your families' lives easier at home to talking with school therapists, etc.
6. Keep anything you share with us confidential.

If you have any questions about the above information, please don't hesitate to ask us. We are here to help you!

I have read and understand the above Clinic Etiquette and agree to abide by it.

____ _______________________

Parent/Legal Guardian Signature **Date**

Guidelines for Parent Training

Your child's success in therapy is very important to the team at Kids Therapy Solutions Corp. You are an important member of the team. The following are recommendations to maximize your child's success in therapy.

1. Attend and be on time for all scheduled parent training appointments.
2. Parents are responsible to attend 2 trainings per month.
3. Parent training will be for one hour per training.
4. Arrive 10 minutes prior to the training to meet your child's therapist to review the session as well as participate in training.
5. If you must cancel, call 24 hours in advance when possible.
6. Communicate any concerns or observations regarding your child. If there are any questions or concerns about therapy, or interventions, please ask for your therapist or call BCBA for further clarification.
7. Follow recommendations and training tips that therapist provides to you on a regular basis.
8. Be mindful when discussing your child's behaviors, major life stressors, or other dynamics with your child's therapist. We recommend discussing significant behaviors or concerns in private.

CANCELLATION POLICY

Our team strives to provide the best therapy services possible. To ensure optimal use of valuable therapy time, **please discuss schedule changes at the end of your appointment with your therapist and the analyst**. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday morning appointments, our office appreciates being notified no later than Friday noontime. This will allow other patients in need of care to be accommodated as we have many patients. It is both unfair to the other patients and therapists to not allow for others to schedule in the open time slots.

Please review and initial all statements below:

______ I understand it is my responsibility to communicate with the front staff/clinic manager of any schedule changes or appointment cancellations.

______ Three consecutive no-shows will require your child to be placed on a hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, your child will lose his/her therapy time and be placed on our information list.

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule.

The above recommendations have been reviewed with me and I agree to follow these guidelines as outlined above.

I hereby understand the above cancellation policy and Guidelines for Parent Training and I agree to abide by it.

____ _____________________

Parent/Legal Guardian Signature **Date**

RELEASE FORM

Patient Name: ____________________________________ DOB: _________________________

[X] I ____ authorize the release of information including diagnosis, records: examination rendered to me and claims information. This information may be released to and from the staff and clinicians of Kids Therapy Solutions Corp along with the following people/places:

Name of Referring Doctor: ____

Specialty: ____

Phone: __________________________ Fax: ______________________________

Name of Primary Doctor: ____

Specialty: ____ Phone: __________________________ Fax: ______________________________

Name of School: ____

Teacher Name: _______________________________Grade: ________________ Phone: __________________________ Fax: ______________________________

Name: Lee County Public Schools. Phone: 2393341102

This release of information will remain in effect until terminated by patient or guardian in writing

Printed Name of Parent/Guardian: ____

Relationship to patient: ___________________________Signature: _______________________________

ADMISSION DOCUMENTS ACKNOWLEDGEMENT

I acknowledge receipt of, understanding of an agreement with all documents listed below ("Admission Documents"), given to me by KIDS THERAPY SOLUTIONS CORP I was given an opportunity to ask questions regarding below listed admission documents and to participate in my plan of care. I was informed that I may terminate any or all services provided by the Agency at any time, with or without cause and without any penalty for termination.

ADMISSION DOCUMENTS

CLIENT SERVICE AGREEMENT AND POLICY

EMERGENCY AND DEMOGRAPHIC INFORMATION

GRIEVANCE PROCEDURES

MEDICATION PROFILE

CONSENT AND RELEASE OF INFORMATION

PRIVANCY OF INFORMATION

X ________________________________ ________________________________

Signature By (**Name of Signor**) **Date**

☐ As Attorney-In-Fact, ☐ As Legal Representative, or ☐ As ____________________________

SERVICE PROVIDER ATTESTATION

On the date/time specified below, I have personally performed this admission/treatment visit for above patient. Above-listed admission documents were provided, explained and accepted by the patient.

Visit Date: _______/_______/________ **Visit Time:** ______:______ **AM / PM**

NAME: _________________________,**Title:** ______**SIGNATURE: X** ______________________________

CLIENT SERVICE AGREEMENT-ADMISSION DOCUMENTS AND POLICIES

KIDS THERAPY SOLUTIONS CORP (collectively referred to herein as Provider, We, Us, Our) and the **Client/Caregiver/Representative**, (collectively referred to herein as "I", "You", "Your", "My", "Patient") have voluntarily entered into this agreement, where the provider agrees to provide, and Client wishes to receive applied behavior services (the "Services) as follows:

PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have been made aware of my rights and responsibilities as a patient and I understand them. The State hot line number has been provided and explained to me, I acknowledge that I have chosen this Provider to provide applied behavior services. No employee of this Provider has solicited or coerced my decision in selecting a behavior services Provider.

1. You will receive professional services not considering religious or political affiliation, national origin, creed, race ethnicity, age, gender, sexual orientation, economic status, disability, or veteran status.
2. Information will be provided in relation to our services. Please, if you have any questions answer could be given counting with our best ability.
3. You will have participation into propose and implementation of an individualized support plan.
4. You may request a change of service provider through discussion of your request with your service provider.
5. You have the right to evaluate, in the presence of a staff member, any information about yourself.
6. You may terminate services at any time.
7. You have the right to referrals to other community services and advocacy on your behalf to ensure the coordination of services and optimal benefits for you.

RESPONSABILITIES:

1- To be involved in the development of your services.
2- Only Behavior Analysis/ Assistant services the caregiver MUST actively participate Participation means:
A- Be at home at schedule time.
B- Work with the analyst for the entire session unless directed otherwise.
C- Complete assignments as required, make changes in environment as needed, and follow recommendation given by the service provider.
D- Carry out Behavior Plan as written.
3- To provide accurate information with all forms and request for information.
4- To refrain from violent or threatening behavior of services.
5- To refrain from the use of mood-altering substances during the course of service.
6- To accept a referral to another provider of services.
7- To cooperate should your counselor make a referral for physician consultation.
8- Notify at once if illness or other emergency required rescheduling.
9- If a fail to meet the above conditions, I understand that services may be terminated.

RIGHTS OF ALL PERSON WITH DEVELOPMENTAL DISABILITIES

Chapter 393.13 of the Florida Statute and Human Care.

1. To Dignity, Privacy and Human Care. 2.
   To Religious Freedom
3. To an Appropriate Program of Quality Education and Training Services within Available Resources.
4. To Social interaction and Participation in Community Activities.
5. To physical Exercise and Recreational Activities
6. To be free from Harm Including Unnecessary Physical, Chemical, or Mechanical Restraint, Isolation, Excessive Medication, Abuse, or neglect
7. To have Right to Consent to or Refuse Treatment.
8. A Right Not be Discriminated Against or Denied Benefits Due to Developmental Disability
9. To Vote.

I have read or been explained a copy of my rights and I have a chance to talk about them. I know I can ask to talk to them at any time and I will be assisted in understanding them.

CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT

I have been involved in and understand my plan of care/treatment and all procedures involved in my treatment have been explained to me and I understand the risks of and alternatives to such treatment. I've been made aware of my discharge plans and goals. I acknowledge that no guarantees have been made to me as to the result of my treatment and that this consent is intended as a

release of KIDS THERAPY SOLUTIONS CORP, and the staff involved in my care from all liability for any injury sustained by me from my treatment (excepting acts of negligence on the part of KIDS THERAPY SOLUTIONS CORP, or the staff).

I understand that the Provider will supervise services provided, I may refuse treatment or terminate services at any time and the Provider may terminate their services to me as Provider's transfer and discharge policy, which was explained to me.

EMERGENCY MEDICAL SERVICES

I understand that during the course of my treatment the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. I understand that the Provider does not provide emergency medical care and therefore should the need for such treatment and/or transfer be deemed necessary and appropriate, the Provider staff will call 911. I consent to such emergency treatment and/or transfer to a hospital and I hereby indemnify the Provider, its owners, staff and physician who may be in attendance from any loss resulting from such emergency treatment and/or transfer. I agree to assume sole responsibility for all charges incurred for such treatment/transfer.

RELEASE OF INFORMATION

I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that the Provider may use or disclose protected health information about me to carry out treatment, payment or health care operations. I hereby authorize KIDS THERAPY SOLUTIONS CORP to release to or to receive from: hospitals, physicians or other agencies/organizations/facilities involved in my care, all medical records and information pertinent to my care, without limitation on history or illness, diagnostic or treatment type. I hereby give permission for the review of my medical records by the regulatory bodies. My consent shall remain valid until I terminative it or for maximum term as allowed by law.

CONSENT TO PHOTOGRAPHS / VIDEOS

I grant permission for KIDS THERAPY SOLUTIONS CORP, personnel to take photographs and/or videos concerning treatment of my illness or injury with the understanding that such photographs and/or videos will be used as additions to my medical record and/or for teaching purposes.

ADVANCE DIRECTIVES

I understand that the Federal Patent Self-Determination Act of 1990 requires that I be made aware of my rights to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advanced Directive (Living Will / Healthcare Surrogate Designation) so that my wishes may be known when I am unable to speak for myself. Information on such Advanced Directives was provided/explained to me.

BEHAVIOR SERVICE CONFORMITY

You will receive professional services not considering religious or political affiliation, national origin, creed, race ethnicity, age, gender, sexual orientation, economic status, disability, or veteran status.
You will have participation into propose and implementation of an individualized support plan.
The information you release to KIDS THERAPY SOLUTIONS CORP is confidential. The exceptions include:

1- If you sign specific consent giving authorization for information to be released.
2- Family counseling all participants must give consent for information to be released.
3- If there is suspicion or knowledge of physical or sexual abuse and/or neglect to a minor, aged Person or person with handicap. The service provider is under ethical obligation and required by law to report the information to the proper authorities and/or professionals.
4- If required by law or court of law.

INDIVIDUAL TREATMENT CONSENT

I understand that I am signing; I am giving consent to KIDS THERAPY SOLUTIONS CORP to implement the communication objectives procedures specified by the analyst (Assessment of basic Language and Learning Skill-Revised) and explained to me. I am giving my consent of free will and accordingly without coercion. I also understand that I have the right to refuse to give consent without penalty or retract consent at any time.

REPORTING MEDICAL FRAUD

WHY IT IS IMPORTANT?
The Medicaid program is funded with both state and federal tax dollars. It is designed to pay for health care for low-income and vulnerable Floridians (children, pregnant women, disable adults and seniors) who need care. When people get benefits, they don't deserve, or when providers are paid for services that were not supplied, it wastes your tax dollars and takes services away from those who need them.
WHAT IS MEDICAID FRAUD?
Medicaid fraud means an intentional deception or misrepresentation made by health care provider with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under federal or state law related to Medicaid. To report suspected Medicaid Fraud, please call the Attorney General toll-free at 1-866-966-7226. Find out if you are eligible for a reward. Callers may request to remain anonymous.
HOW TO REPORT FRAUD?

You can help protect your tax dollars by reporting suspected fraud by phone, through the Internet or by regular mail. You can do this without giving your name, but if you agree to give your name and other contact information, that helps the investigators to obtain future information.
BEFORE YOU MAKE A REPORT, TRY TO GET AS MUCH INFORMATION AS POSSIBLE, INCLUDING:

- The name of the person you suspect of committing fraud. This might be a person receiving medical benefits or a health care professional hospital, nursing home, or other facility that provides Medicaid services
- The Medicaid ID number
- The date of services
- The amount of money involved, and/or
- A description of the acts that you suspect involve fraud.

OTHER TERMS

I agree not to employ directly any Provider personnel/staff for a period of 180 days following my discharge from the Provider. In the event I violate the above condition, in addition to all remedies available to Provider, I shall pay to Provider upon demand the sum of $5,000.00 in liquidated damages or up to maximum amount allowed by law. I agree to the terms of Net Due upon receipt and to pay interest on unpaid accounts over 30 days at the rate of 1 ½ % per month (Annual Percentage Rate of 18%) or the highest legal interest, whichever is lower, together with reasonable attorney fees or costs of collection.

I will provide a safe environment for Provider employees and/or contractors ("Staff")

I will not: (a) ask/have Provider staff perform any duties outside established Plan of Care, (b) allow any of the following and therefore will not hold Provider liable: (I) Lend/borrow money to/from Provider staff, (II) Handling of any financial transactions, including cash, (III) Handling of valuable items, (IV) taking procession of or making use of any personal/valuable item (whether lent or gifted).

OTHER TERMS

X ______________________________ ______________________________ ____________

Signature By (Name of Signor) Date

☐ As Attorney-In-Fact, ☐ As Legal Representative, or ☐ As ______________________

GRIEVANCE PROCEDURE

It is the policy of **KIDS THERAPY SOLUTIONS CORP** not to discriminate, including on the basis of disability. **KIDS THERAPY SOLUTIONS CORP** has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action, including those prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.794) of the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 prohibits discrimination on the basis of disability in any program or activity receiving Federal financial assistance.

The Law and Regulations may be examined in the office of **Company Representative and phone number**, who has been designed to coordinate the efforts of **KIDS THERAPY SOLUTIONS CORP** to comply with Section 504.

Any person who believes she or he has been subjected to discrimination, including on the basis of disability may file a grievance under the procedure. It is against the law for **KIDS THERAPY SOLUTIONS CORP** to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance and such retaliation will not occurs.

PROCEDURE

1. Grievances must be submitted to the Section 504 Coordinator within seven (7) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
2. A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
3. The Section 504 Coordinator (or his/her designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records COMPANY NAME **relating** to such grievances.
4. The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.
5. The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the ***Provider representative*** within 15 days of receiving the Section 504 Coordinator's decision.
6. The ***Provider representative*** shall issue a written decision in response to the appeal no later than 30 days its filings.
7. The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U.S. Department of Health and Human Services, Office for Civil Rights.

KIDS THERAPY SOLUTIONS CORP will make appropriate arrangements to ensure that disabled persons are provided other accommodations, if needed, to participate in this grievance process. Such arrangements may include, but not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

X ______________________________ ______________________________ ____________

Signature By (Name of Signor) Date

☐ As Attorney-In-Fact, ☐ As Legal Representative, or ☐ As

Privacy of Information AND Company Important Policies

Our legal duties

State and Federal laws required that we keep your medical records private. Such laws required that we provided you with this notice informing you of our information policies, your Rights and our duties. We are required to abide these policies until replaced or revised. We have Rights to revise our privacy for all medical records, including records kept before policy change were made. Any changes in this notice will made available upon request before changes take the place.

The contents of material disclosed you provide us, and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of information about you may by the personnel associated with KIDS THERAPY SOLUTIONS CORP for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with KIDS THERAPY SOLUTIONS CORP such billing, quality enhancement, training audits, and accreditation.

Both verbal information and written records about client cannot be shared with another party without the written consent of the client or client's legal guardian or personal representative. It is the policy of KIDS THERAPY SOLUTIONS CORP release any information about client without a signed release of information except in certain emergency or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below and there may be other provisions provided by legal requirements.

Duty to Warn and Protect.

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In case in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety

Health records may be release for the public interest and safety for public health activities, judicial and administrative proceeding, law enforcement purposes, serious threats safety, essential government functions, military and when complying with worker's compensation laws.

Abuse

If a client states or suggest that he or she l) is abusing a child or vulnerable adult or 2) has recently abused a child or disable adult, or a disabled child or adult 3) is in danger or abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is a victim of abuse, neglect, violence or a crime victim and their safety appears to be risk, we may share this information with law enforcement officials to help prevent occurrences and capture the perpetrator.

Reporting Abuse/Neglect/Exploitation to The Florida Abuse Hotline TELEPHONE: 1-800-962-2873

TDD (telephone Device/or the Deaf): 1-800-453-5145 FAX: 1-800-914-0004

In the event of a client Death Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the event of a client's Death

In the event of a client's death, the spouse or parents of a decease client have a Right to access their child's or spouse's record.

Professional Misconduct.

Professional Misconduct by the health care professional must be reported by the other health care professionals. In cases which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be release in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the rights access the client's records.

Other Provisions

When payment for services are the Responsibilities of the client or a person who has agreed to providing payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress note, testing) is not disclosed. If a debt remains unpaid it may report to the credit agencies and the client's credit report may state the amount owed, the timeframe and the name of the KIDS THERAPY SOLUTIONS CORP or collection source.

Insurance companies, managed care and other third- party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, date/times of services, diagnosis, treatment plan, description of impairment, progress of therapy and summaries.

Information about client may be disclosed in consultations with other professional in order to provide the best possible treatment. In such cases the name of the client or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated typed within the KIDS THERAPY SOLUTIONS CORP

If the person answering the phone asks for more identifying information, we will say that is personal call. We will not identify KIDS THERAPY SOLUTIONS CORP (to protect confidentially) If we reach an answering machine or voicemail, we will follow the same guidelines.

Other Client/Legal Guardian/Parents Rights

You have the Right to request to review or receive your medical files. The procedure for obtain a copy of your medical information is follow: You may request a copy or your records in writing with original (not photocopied signature). If your request is denied, you will receive a written explanation of the denied. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is up to $1.00per page, plus postage.

You have the rights to cancel release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our titles. You may request that information be changed, although we might deny changing the record, you have right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this is writing.

If you desired a written copy of this notice, you may obtain it by requesting it from KIDS THERAPY SOLUTIONS CORP

X ______________________________ ______________________________ ____________

Signature By (**Name of Signor**) **Date**

☐ As Attorney-In-Fact, ☐ As Legal Representative, or ☐ As ________________________

ABA Therapy Benefits and Risks

Benefits:

1. ABA therapy is a safe and effective way to treat autism spectrum disorder (ASD).
2. ABA can be easily adapted to individual needs and goals, making it highly personalized for each person who uses it.
3. It can be used in a variety of settings, including home, school, or community-based programs.
4. ABA therapy has been shown to help improve social skills, communication skills, academic performance, self-care abilities and behavior management.
5. It helps individuals learn adaptive behaviors that help them become more independent and able to function better in society.
6. With the help of an experienced ABA therapist, families learn to understand and cope better with their child's autism.

Risks:

1. Depending on the severity of the individual's ASD, it can require hours of therapy for it to be effective.
2. It requires considerable time and commitment from both the family as well as the professional's providing treatment.
3. Some people may feel uncomfortable with some ABA techniques that involve rewards or punishments.
4. Costs associated with ABA therapy can be high, depending on where you live and how frequently your child needs to see a therapist.
5. There is limited research on long-term effects of ABA therapy, so the benefits may not be permanent.
6. Not all therapists are adequately trained and qualified to provide ABA therapy services, so it is important to do your research before beginning ABA therapy.

Despite the cons, ABA therapy has been proven to be an effective treatment for autism spectrum disorder (ASD). If you are considering ABA therapy for yourself or a loved one, make sure you discuss the pros and cons with your healthcare provider to find the best course of action for your individual needs.
With patience and commitment from both the family and professionals involved, aba therapy can have positive results that help individuals with ASD learn new skills, improve communication abilities, manage challenging behaviors, and become more independent in their communities.

X ______________________________ ______________________________ ____________

Signature By (**Name of Signor**) **Date**

☐ As Attorney-In-Fact, ☐ As Legal Representative, or ☐ As ______________________________

PATIENT'S CHOICE AND CONSENT TO REQUEST/RELEASE/REVIEW MEDICAL RECORDS

I,____, have chosen **KIDS THERAPY SOLUTIONS CORP** as my child's Behavior Therapy Provider.

Patient Name______________________________ DOB ____________________.

I give **KIDS THERAPY SOLUTIONS CORP** consent for my treatment, including permission to request/review my medical records (PHI) from any current or past admission to any facility, such as but not limited to:

Referral Letter

Medical Record

Academic Records and IEP

Psychiatric Evaluation Psychological Evaluation Hospital Discharge

Vocational Evaluation Medication Employment Information

Alcohol /Drug Treatment

Vocational Rehabilitation Information Other Service Record

I authorize any such facility to release any and all of my health records (PHI) to **KIDS THERAPY SOLUTIONS CORP** This consent/permission shall remain in force until rescinded by me or for as long as may be permitted by law.

x____ ___/___/___

Patient' Representative Signature **Date**

x____

Relation with the Patient

700 South Main Street. LaBelle, FL 33935
info@kidstherapysolutions.com

Media Consent

Purpose: To obtain written patient consent for use of photos, videos, and testimonial/commentary, training, instruction, or other uses.

Agree Statements

I grant permission for KIDS THERAPY SOLUTIONS CORP, personnel to take photographs and/or videos concerning treatment of my illness or injury with the understanding that such photographs and/or videos will be used as additions to my medical record and/or for teaching purposes.

This consent signed permission expires (1) year after the date signed.

This consent will be renewed annually or at the expiration date, whichever comes first.

You can rescind consent at any time and without penalty, you just have to formally ask by email to info@kidstherapysolutions.com and they will send back a Rescind Consent form for you to sign.

____

Patient' Representative Signature/ Date

____

Patient' Representative Name