Hudson Valley Licensed Behavior Analyst

Client Name: _____

Date packet handed in: _____

Desired assessment date/time: _____

Thank you for selecting us at Hudson Valley Licensed Behavior Analyst to help you meet the needs of your child! We know you have many options to choose from and appreciate your having selected us to assist you with this important process.

The attached packet will allow you time to gather information prior to your appointment that will be helpful in the evaluation of your child. If you cannot make your appointment we require 48 hours' notice (business hours) in non-emergency situation.

Thank you for the trust that you are placing in us to assist you and your family. We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information we have, the better able we will be to assist you and your family. If at any time in this process you have any questions please don't hesitate to contact us.

We look forward to meeting you and your child,

Hudson Valley Licensed Behavior Analyst

What Information Should I Bring to My Child's Assessment?

In order for us to provide you with the most accurate and complete assessment, we must have access to the developmental, treatment, medical, and educational history of your child. Without access to this information, the diagnostic process is significantly restricted.

The following information needs to be provided prior to the first evaluation with your child in order for us to be better able to select appropriate testing options for that first session. Releases are included in this packet to aid in gathering this information from other providers.

Required:
□ Informed Consent
□ Authorization to Release Information (HIPPA)
□ Emergency Information
□ Email Communication Consent
□ Treatment Agreement
□ Service Needs
□ CMS 1500 Form
□ Insurance Card

If your child is receiving Special Education Services:
□ Current 504/IEP Document (and Behavior Intervention Plan – BIP – if applicable)
□ All Evaluation Reports
□ Information regarding behavior and academic performance

Private Evaluations, including:
□ Psychological – Psychiatric
□ Neurological
□ Therapy: Speech, Occupational, Physical, etc.
□ Progress reports/Documentation of Goals/status report

□ Other Medical Records:
• Records of last regular visit with primary physician/pediatrician
• Records of visits with specialists (ENT, Gastroenterology, orthopedics, developmental pediatrician, optometrist, audiology, etc.)
• Current vision and hearing status/evaluations
• Records of current & past medications (both prescription and over-the-counter plus "supplements" and "natural" substances)
• Records of illnesses, surgeries, accidents, and hospitalizations

If your child has received specialized therapists, such as ABA, PT, OT or other therapies, we need to review summaries of those therapies.

We always appreciate the effort it takes to organize, track, and provide all this information. We will be happy to make copies at the clinic of any materials that you bring with you.

If you have any questions regarding the evaluation process, or the information contained in this handout, please contact us. Thank you!

Client-Parent Information

Please complete the following client-parent information.

All of the following information is required by HVLBA and updated annually. Please be as complete and accurate as possible.

Client Information

Last _____First _____Middle _____

Date of Birth _____ Social Security Number _____ - _____ -_____ Gender of Child: Male ____ Female: _____

Address _____

City _____ State _____ Zip _____ Home Phone _____ - _____ -_____

Father's Name/Information

Title _____ Last _____ First _____ Middle _____

Home Address (if different from Student's) _____

Home Phone _____ - _____ -_____

Email _____

Business Name _____Position _____ Bus. Phone _____ - _____ -_____

Business Address _____

Mother's Name/Information

Title _____ Last _____ First _____ Middle _____

Home Address (if different from Student's) _____

Home Phone _____ - _____ -_____

Email _____

Business Name _____Position _____ Bus. Phone _____ - _____ -_____

Business Address _____

***If parents are separated or divorced*, to whom shall we send the following?**

General correspondence: Mother _____ Father _____ Both _____

Copies of assessments, treatment reports, etc. : Mother _____ Father _____ Both _____

Billing, Insurance: Mother _____ Father _____ Both _____

School Information

School currently attending _____

Street Address _____

Town/City _____ State _____ Zip code _____

School phone number: _____

Current grade: _____

Age appropriate grade level: Y N

Services received (OT, Speech, PT, other):

_____

_____

_____

_____

_____

_____

Please submit copies of recent report cards, BIP, evaluations, and any other information regarding behavior and academic performance.

Informed Consent for Treatment

I **(do/do not)** give consent for evaluation and treatment to be provided for myself/my child by Hudson Valley Licensed Behavior Analyst.

Hudson Valley Licensed Behavior Analyst will utilize Applied Behavior Analysis (ABA) principles. ABA is the use of behavioral methods to measure behavior, teach functional skills, and evaluate progress. A unique plan will be created that results in long-lasting positive outcomes and an enhanced quality of life. Behavioral treatments are clinical processes that involve a professional arrangement. Therapy is regulated by laws, ethics, your rights as a client, and by standard business practices. Before intervention can begin, your agreement to the business practices described herein is required.

Treatment Termination

If at any time during the course of your treatment it is determined services cannot continue, a Transition to Termination notice can be provided to you explaining the justification for this decision. Ideally, services end when treatment plan goals have been achieved. Additional conditions of termination can include:

- You have the right to stop treatment at any time. If you make this choice, referrals to other therapists may be provided (if available).
- Other legal or ethical circumstances may arise and lead to termination of treatment, such as the clinical expertise of the Consultant being inappropriate or insufficient for the client/individual receiving treatment. Please note: the Consultant will not diagnose, treat, or advise on problems outside the recognized boundaries of her competencies.
- Other situations that warrant termination may include: drug abuse, disclosing illegal intentions or actions, inappropriate behavior during services, or failure to meet parent participation expectations.

Possible Risks Associated with Treatment

Like many things in life, therapy/behavioral treatment has inherent risks. Some of these risks are:

- Disruptions in your daily life that can occur because of therapeutic changes
- No promises can be made regarding learner progress. Some individuals progress and learn skills quickly, while other learns take longer to learn skills or experience difficulty retaining skills once learned
- Initial increases in the duration, frequency, or intensity of problem behaviors due to the "Extinction Burst"
- Although treatment begins with the hope of behavioral improvement and positive outcomes in the overall family functioning, there is no guarantee that this will occur. There is, however, a better chance of improvement occurring if all caregivers in the household participate in the therapy.

Possible Benefits Associated with Treatment

Multiple studies across decades of time have contributed to the current understanding of the benefits of Applied Behavior Analysis:

- Improvements in communication, social relationships, play, self-care, school, and employment
- Increased participation in family and community activities

- Improvements in “school readiness”
- Significant improvements (socially valid improvements) in learning, reasoning, and adaptability to change

Your signature below will verify that you have read all of the information contained in this Informed Consent and that you asked questions about anything you have not understood up to this point.

By signing, you freely acknowledge your willingness to undergo treatment using Behavioral Therapy methods:

I acknowledge that Therapy involves potential physical, emotional, and mental risks, including but not limited to the potential for property damage, personal injury, and emotional duress. I acknowledge that proper implementation of Applied Behavior Analysis requires ongoing training and support from a Board Certified Behavior Analyst, adherence to the treatment plan, and diligence in data collection.

Date: _____

Name of individual receiving treatment: _____

Guardian/Parent Name: _____

Guardian/Parent Signature: _____

Authorization to Release Information

A. I, _____ (client's name), DOB _____ (client's DOB), do hereby consent to and authorize Lisa Rinaldo, Licensed Behavior Analyst, and Hudson Valley Licensed Behavior Analyst, including employees to disclose/obtain from:

Name of person/facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

B. I hereby (do/do not) authorize the source named above to send, as promptly as possible, the records listed below marked below to Hudson Valley Licensed Behavior Analyst.

□ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness: _____
□ Date(s) of inpatient admission & discharge: _____

□ Start of outpatient treatment: _____ End of treatment: _____

□ Other identifying information about the service(s) rendered: _____

□ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.

□ Psychiatric evaluations, reports, or treatment notes and summaries.

□ Treatment plans, recovery plans, aftercare plans.

□ Admission and discharge summaries.

□ Social histories, assessments with diagnoses, prognoses, recommendations, and all similar documents.

□ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.

□ Workshop reports and other vocational evaluations and reports.

□ Billing records.

□ Academic or educational records.

□ Report of teachers'/staff observations.

□ Achievement and other tests' results.

□ A letter containing dates of treatment(s) and a summary of progress.

□ Drug and Alcohol information contained in these records will be released

□ HIV-related information and contained in these records will be released

□ Other: _____

C. I further authorize the source named above to speak by telephone with staff of Hudson Valley Licensed Behavior Analyst (identified in the letterhead) about the reasons for my/the patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

D. I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan. The information disclosed may be used in connection with my/the patient's treatment.

E. This request/authorization to release confidential information is protected by Federal Regulation 42CFR Part 2, and cannot be released without my written consent unless otherwise required by law. I understand that I need not consent to the disclosure of information in order to obtain treatment services.

F. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

G. This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 365 days from the date I signed it.

H. I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

I. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

_____

Name of Client

_____ _____ _____

Signature of Parent/Guardian Printed name of Parent/Guardian Date

Emergency Contact Information

Emergency Contact #1

First Name _____ Last Name _____

Relation to child _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ - _____ -_____

Work Phone _____ - _____ -_____

Cell Phone_____ - _____ -_____

Emergency Contact #2

First Name _____ Last Name _____

Relation to child _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ - _____ -_____

Work Phone _____ - _____ -_____

Cell Phone_____ - _____ -_____

Emergency Contact #3

First Name _____ Last Name _____

Relation to child _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ - _____ -_____

Work Phone _____ - _____ -_____

Cell Phone_____ - _____ -_____

Alternate Pick Up Authorization

Please list those people in addition to parents/guardians who are permitted to pick up your child:

First Name _____ Last Name _____

Relation to client _____

Cell Phone_____ - _____ -_____

First Name _____ Last Name _____

Relation to client _____

Cell Phone_____ - _____ -_____

First Name _____ Last Name _____

Relation to client _____

Cell Phone_____ - _____ -_____

First Name _____ Last Name _____

Relation to client _____

Cell Phone_____ - _____ -_____

Medical Information/ Authorization: Health History

Client Name: _____ Date of Birth: _____/_____/_____

Insurance Information

Policy Number_____

Name of Health Insurance Provider_____

Primary Physician_____

Address_____

Phone_____ Hospital Preference_____

Please list any health/medical problems requiring maintenance medication (i.e. Diabetic, Asthma, Seizures, etc.)

Medical Problem	**Required Treatment**	**Should paramedics by called?**
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No

Is your child presently being treated for an injury or sickness, or taking any form of medication for any reason?
Yes____ No____ If yes, explain: _____

Does your child require a special diet?

Yes____ No____ If yes, explain: _____

Is your child allergic to any type of food or medication?

Yes____ No____ If yes, please explain below.

Does your child have any medical allergies? For example, Penicillin. If yes, please list them.
_____
_____
_____

Does your child have any food allergies? For example, peanuts, gluten, milk etc. If yes, please list them.
_____
_____
_____

Does your child have any activity restrictions? If yes, please list them.

_____

_____

_____

Physician Name: _____

Physician Address: _____

Physician Phone: _____

Specialist/Other Doctor: _____

Medical Insurance: _____

Medical Insurance Number: _____

Preferred Hospital: _____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problems, which may interfere with or alter treatment.

Parent Authorization:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except noted by more or physician. I understand that I will be notified in the case of a medical emergency involving my child. In the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event my child is injured or becomes ill.

Signature of Parent/Guardian _____ **Date:** _____

HVLBA Medication Form

Please list all medication child is taking (including OTCs & supplements):

_____ _____

_____ _____

Is your child going to be taking any medications listed above during services? YES NO

Please provide the following information if you circled **YES**. Please note, all medications must be provided (including OTCs such as Tylenol) in original prescription bottle with medication name and child's name.

Medication cannot be accepted if:

- There is no prescription
- Medication is expired
- Medication is not in original bottle

1. Medication Name: _____

Dosage: _____ Administration Time(s): _____

Medication Form (liquid, pill, powder, etc.): _____

How does your child prefer to take medication (in juice, with pudding, whole, etc.)?

_____

2. Medication Name: _____

Dosage: _____ Administration Time(s): _____

Medication Form (liquid, pill, powder, etc.): _____

How does your child prefer to take medication (in juice, with pudding, whole, etc.)?

_____

Hudson Valley Licensed Behavior Analyst (HVLBA) Health Policy

In order to maintain optimum health for our clients and staff we ask to, please, keep sick children home from program. Please refer to the outlined guide below if there is a need to keep your child home sick. A doctor's note is required if your child is absent two or more days that must be handed in upon return of your child.

- **Fevers**
  - Any fever obtained 100.4 or over
  - Fevers can be an indication your child is fighting off an infection
  - Fevers can be contagious
  - Fevers can be accompanied by: sore throat, rash, ear ache, irritability, and confusion
  - Child should be fever-free for 24 hours before returning to school without the aid of medication
- **Diarrhea**
  - 2 or more stools in 4 hours that are loose, runny, or bloody
  - After 2 days without diarrhea, child may return to school
- **Vomiting**
  - 2 or more times in a 24 hour period
  - After 2 days without vomiting, child may return to school
- **Respiratory**
  - Breathing trouble
  - Sore throat
  - Swollen glands
  - Loss of voice
  - Continuous coughing

Please use your own discretion during these situations. Please note, the outline is only a guideline and are not limited to these examples. If your child presents with any symptoms at school, they will be required to be picked up based on the onset of symptoms at discretion of the school nurse and teachers.

Email Communication Consent

Client/Guardian Name: _____

Risks: The confidentiality of e-mail communication cannot be assured

- E-mail communication may be viewed by third parties.
- E-mail is sent across an open computer network & is generally unencrypted. It is thus accessible to prying eyes similar to a postcard.
- E-mail sent using an employer's e-mail system could legally be read by the employer
- The biggest threat to the confidentiality of e-mail is not hackers intercepting messages, but messages that are misaddressed, mistakenly forwarded to others, or are read using shared e-mail accounts or on computer screens when one forgets to log-off

Benefits:

- Use of e-mail may eliminate "telephone tag" between client and health care provider
- Non-urgent messages and questions may be communicated with less interruption than by phone
- Email allows a written record of communication, which can be a useful resource

Appropriate uses of e-mail for medical communication include:

- Addresses and telephone numbers of referring facilities
- Assessment results with interpretation and recommendation
- Before admission and after discharge instructions
- Client education
- Questions and answers about issues discussed during a previous visit
- Questions and answers about new symptoms by an established client
- Verification of future appointment dates/times
- Other messages of a similar nature to the topics above

E-mail should not be used to communicate:

- Emergencies and other time-sensitive issues
- Sensitive information, defined as any information that the client would not want anyone other than the health care provider to have

I, _____ (name of client/guardian) understand the risks, benefits, and appropriate uses of e-mail communication with my providers.

_____ I have reviewed this information above and wish to proceed.
_____ I do not wish to have staff correspond with myself or other therapists by email.

_____ _____ _____

Parent/Guardian E-mail Signature Date

Treatment/Assessment Agreement

This agreement is hereby made and into this day of _____ by and between _____ and Hudson Valley Licensed Behavior Analyst.

The said parties, (do/do not) hereby agree to the following:

Consent For Treatment. I give consent for evaluation and treatment to be provided for myself/my child by Hudson Valley Licensed Behavior Analyst. I understand that I can revoke this consent for treatment at any time in writing to Hudson Valley Licensed Behavior Analyst.

Payment Agreement. I assume full responsibility for and agree to pay all costs, charges, and expenses for services rendered. Each bill shall be paid in full at time of service or on date stated on bill. I agree to pay all costs and fees, including attorney fees, in the event Hudson Valley Licensed Behavior Analyst brings any action because of any failure by someone or me on behalf to pay Hudson Valley Licensed Behavior Analyst bills in full.

Preauthorization Requirements. I understand that it is my responsibility to obtain all pre-authorizations and to comply with all requirements of any insurance plan that I am relying on for coverage of Hudson Valley Licensed Behavior Analyst charges.

Medical Authorization. If, in the opinion of a properly licensed and practicing physician, Student needs medical or surgical services which require parent's pre-authorization or consent, parent hereby authorizes, appoints, and empowers the School to act as parent and furnish such consent on parent's behalf. Parent confirms that it is parent's desire that student be furnished with such medical or surgical services as soon as reasonably possible after the need arises. Parent hereby releases and holds the school harmless from any liability which might arise from the giving of such consent. Parent agrees to reimburse the School for any medical expenditures made on Student's behalf. Appendix 4 includes the Health Information for the student, including hospital preference.

Photo Permission. By signing below, the parents hereby consent to the use of photographs, video or other media taken during the course of the school year of the student, including the student's school work or artwork for publicity, promotional and/or educational purposes (including publications, presentation or broadcast via newspaper, internet or other media sources). Parents understand that neither the parents nor the student will be compensated for such use. **If parent does not consent to the use of the student's photo, video, work or other materials, please sign here:**
_____.

Cancellation Policy. Should I be unable to attend my scheduled appointment, I will notify by phone my clinician, leaving a message as necessary. I understand that I will be billed a regular therapy fee if the clinician has not been notified at least twenty-four hours prior to my scheduled visit. Please note that insurance will not reimburse for missed appointments.

Treatment Cooperation. I agree to cooperate with Hudson Valley Licensed Behavioral Analyst's efforts to provide services to my child and my family and I will participate in the treatment process and will follow through with any interventions recommended by Hudson Valley Licensed Behavior Analyst. I agree to notify Hudson Valley Licensed Behavior Analyst of any changes in diets, medication, or the addition of other treatments prior to the onset of these changes.

Therapists. Hudson Valley Licensed Behavior Analyst will supervise and monitor services provided to me by therapists. All scheduling will occur between the therapist and myself. Therapists are not permitted to babysit for their clients at any time or under any circumstance.

Solicitation. I agree not to solicit the Hudson Valley Licensed Behavior Analyst staff that work with my child. This includes babysitting, extra therapy hours, etc.

Risks. I understand that there is a risk associated with any time of therapy or intervention. I agree that to the fullest extent of the law, Hudson Valley Licensed Behavior Analyst shall not be liable to client for any special, indirect, or consequential damages whatsoever, whether caused by Hudson Valley Licensed Behavior Analyst negligence, breach of contract, or other cause whatsoever including, but not limited to, loss of behavioral consulting services and the costs related to locating a new provider of such consulting services. This does not include willful or intentional wrongs.

_____ _____ _____

Signature of Parent/Guardian Printed name of Parent/Guardian Date

Service Needs

Services interested in: Please select the type(s) of therapy services you would like to receive. Please note that while we will attempt to provide the type of service you request, not all services may be available at time of request.

- ☐ Community Based Services
- ☐ Clinic Based Services
- ☐ School Based Services
- ☐ Social Skills Group
- ☐ Toilet Training Program
- ☐ Parent Training

Any concerns/goals to be addressed:

_____

_____

_____

_____

_____

_____

_____