LIVING SOUL LLC

PROVIDER TYPE 39 SERVICES INTAKE PACKET

NEW CLIENT REGISTRATION

Dear Parents/Guardians,

Welcome to the LIVING SOUL, LLC AGENCY! We are grateful that you are interested in our services and look forward to working with you and your family. The agency opened its doors in West Palm Beach of the year 2018. It is based on BA (Behavior Analysis) program that provides one-on-one therapy for children diagnosed with Autism, as well as other Autism Spectrum Disorders. LIVING SOUL looks to provide quality, caring service to each child that is enrolled. Each staff member is highly trained and dedicated to meet the needs of the families and children they serve.

The first step in enrolling in our service is completing the necessary paperwork for your child. Please thoroughly fill out each page of the client application packet that is provided below. Once you have completed the forms we will complete the behavioral assessment. In addition to the application packet, attach all medical documentation relating to the autism diagnosis and a copy of your child's insurance card. I will be in contact with you when I receive the application packet to continue the intake process. If you have any questions along the way, please contact us during our scheduled business hours.

Thanks again for your interest in our service!

Sincerely,
Living Soul, LLC
Livingsoul.llc@gmail.com

Client Start Date: ______________
(Office to complete)
Today's Date: ______________

Client Legal Name: ____
Last Name First Name Middle Initial

Name Client goes by: ____________________ Date of Birth: __________ Gender: __M / F

Home Address: ____

City: ______________________________ State: __________ Zip: _________

Family Information

Client lives with: ______________________________

Parent/Guardian 1
Name: ______________________________Relationship: ____________________

Address: ____________________ City: ______________ State: _____ Zip: ________

Home Phone: ____________________ Cell Phone: ____________________

E-mail Address: ____

Employed by: ______________________________ Occupation: ____________________

Employer Address: ______________________________ Employer Phone: ______________

Parent/Guardian 2
Name: ______________________________Relationship: ____________________

Address: (if different) ____________________ City: ____________ State: _____ Zip: ________

Home Phone: (if different) ____________________ Cell Phone: ____________________

E-mail Address: ____

Employed by: ______________________________ Occupation: ____________________

Employer Address: ______________________________ Employer Phone: ______________

Emergency Contact Information

I give permission to Living Soul to take whatever emergency decisions are judged necessary for the care and protection of my child while under our care.
Please provide the name and phone number of individuals who can be called in case of an emergency when parents/guardians are not available.

Emergency Contact: ______________________________ Relationship: ____________________

Home Phone Number: ____________________ Cell Phone Number: ____________________

Insurance Information

I understand that in some medical situations, the staff will need to contact local emergency resources before the parent/guardian, child's physician and or other adult acting on the parent/guardian's behalf.

Name of Primary Insurance: ____
Member Number/ number: ____________________ Group Number: _____________________
Subscriber Name: __________________________________
Name of Secondary Insurance: (If Primary insurance is private) ________________________________
Member Number: ____________________ Group Number: _____________________
Subscriber Name: __________________________________
I prefer: ___ Pay my balance in full at time of service
___ Pay my balance in full upon receipt of first statement
___ Make payment arrangements prior to services being rendered

Assignment of Insurance Benefits

I understand the confidentially of my records as protected by law. Information about me/my child cannot be released without my consent. I understand I may revoke this consent at any time, and it will automatically expire without my revocation after one (1) year from the date of signature. I hereby give authorization for Living Soul to contact and inform my primary and secondary (if applicable) insurance companies of all medical information included in treatment plans relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressively agree and acknowledge that my signature on this documents authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize the Insurance Companies named above to pay and hereby assign directly to LS all benefits, if any, otherwise payable to me for his/her services. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received and paid to LS will be credited to my account, in accordance with the above assignment.

____ _______________
(Authorized signature of Subscriber) (Date)

Medical Information

Hospital/Clinic Preference: ____

Client's Primary Doctor: ___________________________ Doctor Phone Number: ________________

Allergies: ____

List any medication routinely taken at home: ____

____

Name of medications: ____

List any medical restrictions to client's activities: ____

____

List any special dietary needs: ____

____

Additional Service Providers

Social Worker: ____________________________________ Phone Number: ______________________

Interpreter: _______________________________________ Phone Number: ______________________

School: ____ Grade: ______________________
Teacher's Name: _________________________________ Phone Number: ______________________

Other Providers (if applicable)

Name: _______________________ Type of service: __________________ Phone number: __________

Name: _______________________ Type of service: __________________ Phone number: __________

Therapy Options

LIVING SOUL offers both in-home and community -based therapy for clients enrolled in our program. Please complete the form below to indicate which therapy you prefer for your child. The information you provide will help us to determine the type of therapy you are seeking for your child.

Please circle:

1. What is your 1st preference?
   In-Home Therapy Community-Based Therapy Combination

2. What is your 2nd preference?
   In-Home Therapy Community-Based Therapy Combination NONE

3. Is there a program you would not prefer or unable to participate in?
   YES NO

   If YES, please explain:
   ____
   ____
   ____
   ____

Strengths

Please list all of your child strengths such as drawing, writing, computer, etc.

Main Concerns

Please list any concerns the child may have at home or in the community. This may include, but not limited to, sensitivity (i.e. oversensitive to noises, oversensitive to certain material or texture of food), behaviors, communication, social skills and play skills. Additionally, provide any special accommodations that would help staffs to better support the child's progress.

Possible Reinforcers

Please list all or any preferences that your child has shown and put * next to the ones that are highly preferred in each category. Be SPECIFIC as possible!!

FOOD: (snacks, candies, chocolate – please be specific; kind or brand names)

____

____

____

TOYS: (games, stuff animals, etc.)

PHYSICAL CONTACT: (tickles, hugs, kisses, clapping, back rubs, etc.)

ACTIVITIES: (reading books, listen to music, etc.)

OTHER: (any special preferences not mentioned)

Service Coordination

Child's Name: ____ Date: _______________

Service Coordination:

If your child is receiving any of the following, indicate the number of hours of service per day and the frequency of the service.

Service	Number of Hours	Frequency
Special Education Services		
Child Welfare- Targeted Case Management (CW-TCM)		
Personal Care Assistant (PCA)		
Mental Health- Targeted Case Management (MH-TCM)		
Recreational Therapy		

Psychiatrist		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Family Psychotherapy Services		
Other (explain)		

**If your family is currently not receiving Psychotherapy Services, is this something you are interested in? Please circle below.

Yes No

If no, please list reason(s) why. Circle all that apply.

Not needed at this time Busy Schedule Have tried in the past but not effective

Other: ______________________

Release of Consent

Client name: ____

A separate Consent for Exchange of Information form must be completed for each individual or agency you wish for LS to communicate with.

- I understand that my records are protected by data practice laws and cannot be released without my consent unless otherwise allowed by law.
- I understand that only the information and records indicated below will be released or obtained.
- I understand that this consent does not authorize the recipient of the information or records to re-disclose the information or records to any other person or facility unless authorized by law.
- I understand that the information will only be used for the purposes indicated below.
- I understand that I may withdraw or modify this consent at any time but, that the revocation or modification will not affect any release of information that previously occurred.
- I understand that this consent with expire and no longer be valid **one year** from the date it was signed.
- I understand that the observation and/or assessment can take place in either setting.

I Authorize:

LIVING SOUL

Name of Staff: ____

To obtain records from or release records to:

Name of Agency: ____

Name of Staff: ____

Type of information released:

___Assessments or evaluations ___Educational records

___Behavior reports ___Medical records

___All ___Other: ______________________

Information may be shared in person or by mail. I also give permission to share information using the following methods:

___Phone
___Fax
___All

___Email
___Other: ___________________________

____ _____________
Parent or Guardian or Authorized Representatives Signature Date

Federal Law: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law prohibits disclosing this material. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

LIVING SOUL Consent Form

I, ____________________, as parent/legal guardian of _______________, give permission for my child/ward, (hereinafter "Participant") to participate in the LIVING SOUL BA SERVICE. I have received an enrollment application package and have read, understood and completed all the necessary forms required prior to enrollment. I agree with the current personal development goals established for Participant, and I am aware that I will be required to COMPLETE periodic survey for review and revision of Participant's individual service. I also understand that I may withdraw Participant at any time. I understand that the LIVING SOUL reserves the right to terminate the enrollment of Participant for failure to adhere to program standards.

I have given all emergency contact information to LIVING SOUL.

I also give permission for LIVING SOUL to use any necessary information and data collected on Participant to be reviewed and used in presentations at any professional meetings and conferences. I understand that Participant's name and identity will be kept confidential and will not be disclosed without prior written notification. I also understand that this will serve to further the advances in the field of autism.

I hereby agree to hold harmless and release from any and all liability, the LIVING SOUL, its directors, officers, employees, agents, affiliates, sponsors, and promoters, as well as, their respective directors, officers, employees, and agents (hereinafter collectively known as "the LIVING SOUL, for any injury or illness to the Participant, arising out of or in connection with I agree that health insurance coverage for the Participant is my sole responsibility.

Parent/Guardian comments:

____
____
____
____

____________________________________ ______________
Parent or Legal Guardian Name (Please Print) Date

______________________________________ ________________
Parent or Legal Guardian Signature Date

Client Notification of Privacy Rights

Health Insurance Portability and Accountability Act (HIPAA)

Recent federal law, the Health Insurance Portability and Accountability Act (HIPAA), has created new client protections surrounding the use of protected health information. Commonly referred to as the " medical records privacy law," HIPAA provides client protections related to electronic transmission of data, the keeping and use of client records, and the storage and access to health care records. HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Client Notification of Privacy Rights is designed to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can do to protect the privacy of your mental health records.

HIPAA requires that we secure your signature indicating you have received or been offered the Client Notification of Privacy Rights document.

I have accepted a copy of the Client Notification of Privacy Rights document. ______

I have been offered a copy of the document and do not wish to have a copy at this time. ______

(I understand I have the right to review the document before signing this acknowledgement form.)

______________________________ _________________________________
Client's Name (print) Client or Legal Guardian Signature

________________ ________________
Client Date of Birth Date Signed

Please sign and return this page to the office. You may retain the notification document for you records.

FACE Sheet

Please complete the form below by providing as much information as possible regarding your child. This information will be given to medical personnel in case of an emergency.

Name	
Birth Date	
Parent/Guardian	
Home Address	
Home Phone Number	
Cell Phone Number	
Work Phone Number	
Primary Insurance	Name:
	Member Number:
	Group Number:
Secondary Insurance	Name:
	Member Number:
	Group Number:
Hospital/Clinic Preference	
Primary Doctor	
Allergies	
Other Information	

Parent or Legal Guardian Signature ____________________ Date ____________

Additional Information

Thank you for completing the client registration packet. In addition to submitting the application packet, please include the following items when applying for enrollment:

- Copy of your child's insurance card(s)
- Medical documentation pertaining to the diagnosis of autism
- Reports from other service providers (if applicable)
    - Speech therapy, school services, occupational therapy, etc.

Please contact the center if you have any questions when completing the application packet, or regarding the intake process.

Thanks again,

NOTICE OF PRIVACY PRACTICES

FOR PROTECTED HEALTH INFORMATION

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity.
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.

- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See HHS.gov - Health Information Privacy) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See the state website for health plans, and for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.

- A covered entity must prominently post and make available its notice on any website it maintains that provides information about its customer services or benefits.

    -) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities.

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

You can also go to http://www.floridahealth.gov/programs-and-services/people-with-disabilities/index.html then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.

Description of Services

Description of Services Behavior Analysis (BA) Intervention Services: Behavior and Education Consultants (BCBAs or Licensed Clinicians) provide evidence-based treatment using Behavior Analysis (BA) strategies to teach new skills, develop meaningful learning tasks, address challenging behavior, and support individuals with autism in a variety of settings.

Client-Focused Skills Coaching: BCBAs work directly with the client to build specific skills. This type of therapy is only appropriate when recommended by your BCBA and may not be the best fit for all clients.

Intensive In-Home BA Program: The BCBA/licensed therapists work with families to develop, implement, and refine an in-home, intensive, comprehensive BA-based programs individualized for each child. Home-based programs are implemented by behavior technicians and supervised by the BCBA or licensed therapist.

Hours of Availability

Please mark the times you and the client ARE available for services.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00 am							
9:00 am							
10:00 am							
11:00 am							
12:00 pm							
1:00 pm							
2:00 pm							
3:00 pm							
4:00 pm							
5:00 pm							
6:00 pm							
7:00 pm							
8:00 pm							
9:00 pm							
10:00pm							

Additional Comments

____

____

____

SIGNATURE and ACKNOWLEDGEMENT

Parent/Guardian Signature: ______________________________ **Date**: ___________

I hereby certify that the above statements are true and correct to the best of my knowledge and understand all information in this packet will become part of the patient's clinical file.

____

Printed Name **Relationship to client**