Behavioral Outreach Services, LLC

Phone: 731-446-5441 Email: shiloh.beene@gmail.com Fax: 731-784-2664 https://behavioraloutreach.com

Thank you for considering Behavioral Outreach Services as your ABA Provider (Applied Behavior Analysis). We accept most insurance companies, and also work with private pay clients. If you are considering private pay, call us for current rates. Please note, we do try to serve clients as quickly as possible. In some cases we may start ABA services very quickly (after approval has been received from the insurance company – which takes about 4 weeks). In other circumstances you may be on the waitlist for 3-8 months or so. While these are not usual times frames, it does happen from time to time. Therefore, the quicker you provide ALL required paperwork to us, the sooner we can get you on the wait list for services in order to get started. ***You will ONLY be on the wait list once ALL required paperwork has been received.*** **Thank you for your understanding and patience. If you have any questions, please feel free to contact me at (731) 446-5441 or shiloh.beene@gmail.com.**

✔ REQUIRED information to receive ABA services and/or be placed on our waitlist:

- ○ Behavioral Outreach Services (BOS) **Intake Paperwork completed, signed, and returned.**
  - It is very important to specify all the other services received to date including but not limited to medication management, Counseling, Speech Therapy, Occupational Therapy, Physical Therapy, Play Therapy, etc. and their outcomes in the appropriate places on the BOS Intake Paperwork. The insurance company needs to see that other therapies have been tried first before my services can be obtained. If you have any questions about this you may contact me.
- ○ **Referral from DOCTOR** (MUST be signed by M.D. or Ph.D.) stating these 2 things:
  1.) Diagnosis **(such as Autism, Intellectual Disability, etc.)** with ICD-10 codes
  2.) and says **"refer for ABA services**" (Applied Behavior Analysis services)
- ○ Copy of **front and back of ALL insurance cards** (primary, secondary, etc.)
- ○ A copy of the **FULL Psychological/Psycho-Educational Evaluation** which first diagnosed child with Autism, Intellectual Disability, etc.
- ○ **Email picture** of the child to shiloh.beene@gmail.com (for case file).

✔ OPTIONAL information which can be helpful:

- ○ A copy of child's IEP or 504 plan
- ○ A copy of child's Functional Behavioral Assessment (FBA) from school if one has been done
- ○ A copy of child's Behavior Intervention Plan (BIP) from school if one has been done
- ○ Anything else you think is important

Options on How to get Intake Packet and Required Documents to Us:

1.) Scan in and email to shiloh.beene@gmail.com (preferred method), or
2.) Drop off/Mail to current office attn: Shiloh Beene, West TN Hearing and Speech Center, 65 Ridgecrest Rd, Jackson, TN 38305.

Thank You! Talk to you soon. Sincerely,

Shiloh Beene, M.S., BCBA, LBA
Owner/Executive Director, DIDD Approved Behavior Analyst
Behavioral Outreach Services, LLC

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DISCRIMINATION IS PROHIBITED

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 REQUIRES THAT FEDERALLY ASSISTED PROGRAMS BE FREE OF DISCRIMINATION. THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION, DIVISION OF MENTAL RETARDATION SERVICES ALSO REQUIRES THAT ITS ACTIVITIES BE CONDUCTED WITHOUT REGARD TO RACE, COLOR, OR NATIONAL ORIGIN.

Prohibited Practices Include:

3.) Denying any individual any services, opportunity, or **other** benefit for which he or she is otherwise qualified;
4.) Providing any individual with any service or other benefit, which is different or is provided in a different manner from that which is provided to others under the program;
5.) Subjecting any individual to segregated or separate treatment in any manner related to his or her receipt of service;
6.) Restricting any individual in any way in the enjoyment of services; facilities; or any other advantage, privilege, or benefit provided to others under the program;
7.) Adopting methods of administration that would limit participation by any group of recipients or subject them to discrimination;
8.) Addressing an individual in a manner that denotes inferiority because of race, color, or national origin;
9.) Subjecting any individual to incidents of racial or ethnic harassment, the creation of a hostile racial or ethnic environment, and **a** disproportionate burden of environmental health risks on minority communities.

Should you feel you have been **discriminated against, please contact the local Title VI coordinator.**

Behavioral Outreach Services, LLC

Shiloh Beene, M.S., BCBA, LBA
Owner/Executive Director,
Board Certified Behavior Analyst,
Licensed Behavior Analyst,
Department of Intellectual and Developmental Disabilities
Approved Behavior Analyst

Cell: (731) 446-5441
Fax: (731) 784-2664
Email: shiloh.beene@gmail.com

• Any individual may file a Title VI complaint with the below listed entities. It is preferable that complaints be registered at the local level first.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICE, REGIONAL MANAGER
OFFICE FOR CIVIL RIGHTS — REGION IV
ATLANTA FEDERAL CENTER, SUITE 3B70
61 FORSYTH STREET, S.W.
ATLANTA, GA 30303
(404) 562-7886

Client/Person Supported: _____

Parent/Legal Representative: _____ **Date:** _____

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CONSENTS AND AUTHORIZATIONS FOR SERVICES (R2018)

Client/Person Supported (Print): _____

Consent for Assessment and Treatment Development: I hereby consent to the assessment process and the potential development of a treatment plan from Behavioral Outreach Services, LLC consistent with a plan of care involving behavior modification techniques, applied behavioral analysis, and/or cognitive behavioral treatments. I confirm that I have been informed and have participated in the assessment process and in planning the care and treatment procedures to be carried out and sign this consent willingly and voluntarily.

Voluntary Informed Consent to Treatment: The potentially harmful effects of the procedures described in the Behavior Support Plan may include any of the following: temporary increase in problem behaviors, a temporary decrease in participation in daily activities, emergence of other inappropriate behavior, avoidance of the situation and/or staff associated with the procedures, attempts to escape the situation and/or staff associated with the procedures. The parent/conservator and/or The Circle of Support also acknowledge and give consent to the fact that hands-on treatment methods may be used to decrease escape from tasks, teach new skills, and/or keep the individual, others, or property safe from harm. The parent/conservator and/or The Circle of Support has evaluated the risks and benefits of using the procedures in the Behavior Support Plan and has determined that the potential benefits derived from these procedures outweigh any potential *harmful effects of* the procedures and the impact of these behaviors on this individual's daily life. The behavioral team follows the ethical guidelines of ensuring that the least restrictive potentially effective procedures are always attempted first, and has chosen only those procedures that are necessary to reduce and/or eliminate the inappropriate behavior and to increase appropriate *behavior.* The parent/conservator and/or The Circle of Support also consents to having Behavior Specialists and/or practicum students implement behavioral treatments, under the direct and/or indirect supervision of a Behavior Analyst. Currently, the individual has no known medical conditions that contraindicate the use of the procedures.

Consent to Video and Photograph: I hereby give Behavioral Outreach Services, LLC permission to take and use my image, whether through photographs or video footage, **for safety and identification purposes**. My signature states that I understand it will only be used for the expressed purpose of developing appropriate behavioral treatments and/or creating a photographic history. We never release information for any sort of marketing purposes without first obtaining a separate release of information for marketing purposes form.

Authorization to Release/Obtain Information: I hereby authorize Behavioral Outreach Services, LLC to release to, or receive from hospitals, schools and school personnel, practicum students or college students, lawyers/paralegals/or court system personnel, physicians, psychiatrists, psychologists, counselors, Speech Language Pathologists, Occupational Therapists, Physical Therapists, Independent Support Coordinators, Behavior Analysts, Behavior Specialists, Supported Living Agencies, WTRO staff, Provider Agency Staff, Circle Of Support Members, Behavior Support Committee Members, Human Rights Committee Members, Conservator/Guardian, Primary Care Physician, Regional Monitors, Direct Care Staff, Third party, i.e., insurance/Medicaide/TennCare/Medicare,etc., other agencies or disciplines, or other individuals involved in my care, all medical records, and information pertinent to the continuity of my care. I hereby give permission for the review of my medical record by the State of Tennessee, Court Monitor, PCP, Provider and ISC. Said information may be electronically transmitted, transmitted by video, audio, verbal, or written means.

***Uses and Disclosures Not Requiring Consent or Authorization:** By law, protected health information may be released without your consent or authorization: Child abuse**,** Suspected sexual abuse of a child**,** Adult and domestic abuse**,** Health oversight activities (i.e., licensing board for psychiatry in Tennessee)**,** Judicial or distractive proceedings (i.e., if you are ordered here by court for an independent child custody evaluation in a divorce), Serious threat to health or safety (is, our "duty to warn" law, national security threats) **,** Workers compensation claims (if you seek to have your care reimbursed under workers compensation, all of your care is automatically subject to review by employer and/or insurer(s).

Provider/Client relationship: I am aware that the relationship between provider and patient is a professional one that precludes ongoing social relationships, giving of gifts, or participation in personal events such as parties, graduations, etc. In addition, I understand that I or another responsible adult must be present during all assessment and treatment sessions in the home/community setting and the BOS practitioner is not solely responsible for the patient during that time. **I agree to notify BOS as soon as possible of cancellation. I understand that repeated cancellations or no shows may result in termination of services.**

I have read the above statements and give my informed consent to the assessment and plan development process, and to the implementation of the Behavior Support Plan. I understand that I may cancel this consent to release information, or consent to treatment at any time by written statement. However, I also understand that any release that has been made prior to my revocation, or any treatment provided prior to my revocation shall not constitute a breach of my right to confidentiality. This authorization to release information, and/or to implement behavioral treatment (a Behavior Support Plan) is automatically revoked at the end of one year from implementation date of BSP, if services are not occurring on a continuous basis.

Client/Person Supported (Sign): _____ **Date:** _____

Parent/Legal Representative (Sign): _____ **Date:** _____

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Attendance/Sick Policy Effective Date: 10/26/2018

Behavioral Outreach Services, LLC (BOS) values the opportunity to serve our population and understands the importance that consistent attendance and punctuality serves in upholding the integrity of the ABA services we deliver. As a result, BOS strives to establish consistent schedules in order to limit disruptions to therapy. While it is understood that unexpected circumstances arise, and that it is always the right of the parent/guardian to change or cancel an appointment or terminate a session early, BOS has developed the following attendance/sick policy to help prevent the hindrance towards behavioral goals caused by frequency of these occurrences.

OBJECTIVES: This policy serves to maintain the consistency of service delivery, maintain the availability of clinician for the assigned client, and make services available to those who respect the time allotted.

- **No call/no shows:** If clinician does not receive notification of a cancellation or rescheduling by the start time of the scheduled appointment this is considered a no call/no show. The occurrence will be noted in the client's record. Three (3) no call/no shows can lead to an automatic discharge from services.
- **Illness:** Because we are all susceptible to catching the flu, colds, viral infections, and other contagions the following policy is in place- If your child has one or more of the following symptoms we cannot permit them into the clinic and encourage you to attend your regular weekly appointment AFTER all symptoms have cleared. **Fever (101 degrees or higher), Yellow or Green Drainage from the Nose and/or Eye, Vomiting, Diarrhea, Open/Bleeding Lesions, Swelling/Redness in/or Surrounding the Eye, *Hand/Foot/Mouth Disease*, Unknown Rash, Sore Throat/Swollen Glands, Coughing, Lice/Nits or Worms, Known contagious virus, infection, illness, or disease**. Thank you for helping us prevent the spread of infection to the children and staff of BOS. **Contact BOS by phone call or text at 731-446-5441 as soon as possible to notify them of a cancellation.**
- **Cancellations:** It is not likely that clinicians will be able to reschedule a session during the same week if cancellations occur. Occurrences of cancellation with less than 24-hour notice will be noted in the client's record. If three (3) sessions in a 90-day period are cancelled with less than 24-hour notice or without a doctor's note, the case will be reviewed for discharge. Late arrivals/early departures of more than 15 minutes will be recorded and treated in the same manner.
- **Protocol for cancelling an appointment: Contact BOS by phone call or text at 731-446-5441 as soon as possible to notify them of a cancellation.** If you call and we are in session with another client and can not answer, leave a message. Preferably, 24 or more hours in advance if possible. If a cancellation was due to sickness, a doctor's note can be turned in to excuse this absence.
- **Abrupt Early Termination of Session:** The parent/guardian always has the right to terminate a session early by simply verbalizing the request that the session cease immediately. In the event of abrupt early termination of a session by a parent/guardian, the occurrence will be noted in the client's record. If three (3) of these abrupt early terminations occur in a 90-day period the case will be reviewed for discharge.
- If ABA services are discontinued at any point due to our agreed upon attendance policy, you as the client have been informed and understand that you can access a list of "in network" ABA providers by contacting the member services number on the back of your insurance card to get a list of ABA providers **IF** ABA is a covered benefit on your insurance policy.

By signing below, Client(if competent adult)/Parent or Legal Representative indicates they have read, agree to, and will abide by the attendance policy.

Client/Person Supported (Print): _____

Client (if competent adult)/Parent/Legal Representative (Sign): _____

Relationship to Client/Person Supported (Print): _____ **Date:** _____

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Note: Please fill out a SEPERATE Release of Information for EACH business/provider you would like us to communicate with such as Pediatrician, PCP, SLP, OT, PT, Psychiatrist, School, etc.

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Client/Person Supported Name:_____ **DOB:** _____

Street Address: _____ **City/State:** _____ **Zip:** _____

I hereby authorize Behavioral Outreach Services, LLC to (check all that apply):
❒ Exchange with (Release AND Obtain) ❒ Release to ❒ Obtain from **the parties I have indicated below**

I hereby authorize Behavioral Outreach Services, LLC to exchange / release / obtain information:
❒ Both verbally AND in writing ❒ Verbally only ❒ In written form only

From/to: Behavioral Outreach Services, LLC

From/to:
Contact Name: _____
Business Name: _____
Address: _____
City: _____ **State:** _____ **Zip:**_____
Telephone Number: _____ **Fax Number:** _____
Email Address: _____

Description of Information to be Exchanged/Released/Obtained: (Check All That Apply)

❑ Educational Records	❑ Medical Records
❑ Clinical Records (including behavior analytic, psychological, physical, occupational, speech therapies, etc.)	❑ Evaluations/Assessments, Eligibility Records

I understand that this information will be used for the following specific purpose: (Check All That Apply)

❑ to communicate verbally or in writing regarding behavior issues, attendance issues, challenges at school, medical and/or medication issues, challenges with treatments/therapies, current treatment and/or rehabilitation plan and ensure continuity of care	❑ Other:

Dates to Release: From _____(MM/DD/YYYY) to _____(MM/DD/YYYY) _

I understand this release is voluntary and applies to all programs and services operated under the auspices of Behavioral Outreach Services, LLC (BOS). I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that my protected health information, which is disclosed with this release, may be subject to re-disclosure by the recipient and no longer protected by law. **Behavioral Outreach Services, LLC** is not responsible for any alterations made on its medical record copies, which have been released to any party. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. This authorization automatically expires on _____, **or at completion of services whichever occurs first. I understand that I may revoke this authorization at any time by notifying Behavioral Outreach Services, LLC in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.** This Authorization for Release of Information is given freely, voluntarily and without coercion.

Client/Person Supported: _____

Parent/Legal Representative (Sign): _____ **Date:** _____

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PAYMENT INFORMATION

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

Financially responsible party Name: _____ Relationship: _____
Financially responsible party DOB: _____ SS#: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____
Employer: _____ Occupation: _____

Primary Insurance: _____ Policy Holder: _____
Insured ID #: _____ Insured Group #: _____
Insured Social Security #: _____ Insured DOB: _____
Insurance Company phone #: _____
***Make sure to include a copy of the front AND BACK of each insurance card**

Secondary Insurance: _____ Policy Holder: _____
Insured ID #: _____ Insured Group #: _____
Insured Social Security #: _____ Insured DOB: _____
Insurance Company phone #: _____
***Make sure to include a copy of the front AND BACK of each insurance card**

PAYMENT/INSURANCE AUTHORIZATION-AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the doctor agrees otherwise. I understand that unless the named patient has coverage under a managed healthcare plan (i.e. HMO, PPO, EAP) to which I subscribe and in which the Behavior Analyst is a participating provider, I am personally responsible for the payment of all charges. I understand that as a courtesy the will have my insurance claims filed but that it does not release me of responsibility for payment of these charges. Payment for any charges denied or not covered by my insurance company become my responsibility and I agree to pay these charges. I understand that any court order I have is an agreement between the courts and I — not the Behavior Analyst and I am still responsible for all payments. I also understand that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I further understand and agree that a collection agency and/or courts may be used in the event of delinquent payments and that I realize that such action could require the Behavior Analyst to release to the collection parties involved information which identifies me, diagnosis, dates, services rendered and charges as well as any other information needed on the claim filed. In addition, if I have requested the Behavior Analyst have my charges filed to my insurance company I understand that securing benefits under health insurance or other health plans will require that the doctor provide plan management with confidential patient information including diagnosis, service dates and type of services rendered. Further, I understand that for utilization review, quality assurance and other claim review purposes, it may require the Behavior Analyst to provide my confidential information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health claims made by or on behalf of the named patient. This consent shall remain in effect unless all claims have been fully processed and all review procedures completed. **I understand that if any changes to my insurance plan are made that I will notify Behavioral Outreach Services, LLC (BOS) in writing prior to the changes so that a request for services may be submitted to the new plan. I will also provide copies of the front and back of new insurance cards prior to the change. I understand that if I do not notify BOS and services are rendered, I will be responsible for the fees associated with those services**

Parent/Legal Representative (Sign): _____ **Date:** _____

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We at Behavioral Outreach Services, LLC understand your need for ABA services as soon as possible, whether that is with our company or with another ABA provider. We want to make sure that you know HOW to check your insurance benefits to see if ABA is a "covered benefit," and how to obtain a list of in-network ABA providers (if ABA is a covered benefit). This will ensure that you have access to a list of in-network providers in case we have a waitlist, as well as provide you with a choice.

If you have CoverKids or TennCare (BlueCare, TennCare Select, United Health Care Community Plan, or Amerigroup), then ABA is ***most likely*** a covered benefit if your child has certain diagnosis such as Autism, Intellectual Disability, etc. ABA ***may be covered*** for additional diagnosis but is determined on a case-by-case basis by the insurance company. If you have CoverKids or TennCare, here is how to determine if ABA is a covered benefit for your child, and how to obtain a list of in-network ABA providers:

1. Call the Member Services/Customer Service telephone number on the back of your insurance card
2. Ask to speak with a "Behavioral Health Case Manager"
3. Tell them what your child has been diagnosed with (Autism, Intellectual Disability, etc.)
4. Ask them if ABA is a covered benefit for your child. Please be aware that you may need to tell them about the problem behaviors your child is having.
5. Ask them for a list of ABA providers that serve your area. If ABA is a covered benefit for your child, they will then give you a list of names and telephone numbers for in-network ABA providers and/or also help you find an ABA provider that may be able to help you as soon as possible
6. Write this information down in regards to your phone call to the insurance company:

Date: _____ Time:_____ Name of the person you spoke with_____
Ask for a Call Reference Number (write it down):: _____

If you have Insurance Through Work (Private Commercial Insurance) then ABA May, or MAY NOT, be a covered benefit. Because ABA is such a specialized service, we want to make sure to tell you EXACTLY how to talk with your insurance company in order to know FOR SURE if ABA is a covered benefit or not. Unfortunately, members have been given incorrect information by their insurance company in the past and were frustrated later to find out that ABA was not a covered benefit (it was specifically excluded). So, PLEASE follow these instructions exactly as they are written and **use the EXACT phrases given** for the best chance at finding out if ABA is a covered benefit on your plan, and how to obtain a list of in-network ABA providers if it is a covered benefit:

1. Call the Member Services/Customer Service telephone number on the back of your insurance card
2. Tell the person that answers **"I need to know if ABA (Applied Behavior Analysis) is ON the EXCLUSIONS LIST, if it is SPECIFICALLY EXCLUDED"** *please note: checking this FIRST will save a lot of time, headache, and potentially incorrect information.*
3. If ABA is NOT specifically excluded, ask them **"Is it a covered benefit under the medical side or behavioral health side of my insurance?"** (circle) Medical Behavioral Health
4. If ABA IS a covered benefit, ask them **"Which diagnosis does the insurance company cover ABA for?"** (Autism, Intellectual Disability, etc.) (write down)_____
5. **"How does the ABA provider get pre-authorization for ABA?"** (write down)_____
6. Ask them for a list of ABA providers that serve your area. If ABA is a covered benefit for your child, they will then give you a list of names and telephone numbers for in-network ABA providers and/or also help you find an ABA provider that may be able to help you as soon as possible
7. Write this information down in regards to your phone call to the insurance company:

Date: _____ Time:_____ Name of the person you spoke with_____
Ask for a Call Reference Number (write it down): _____

By signing below, you acknowledge that you have been informed on how to check your insurance to see if ABA is a covered benefit, and how to obtain a list of in-network ABA providers (if it is a covered benefit) in order to obtain ABA services as soon as possible, whether with BOS or not. You acknowledge that if you choose to get on BOS's waitlist that it DOES NOT stop you from trying to seek ABA services elsewhere so that you can get this service as soon as possible. Please be advised that you can not get ABA services from two different places at the same time. You also agree that if you choose to get on our waitlist, and you obtain ABA elsewhere, that you WILL notify us by phone, text, or email that you no longer need our services so that we can take you off the waitlist.

Client/Person Supported: _____

Parent/Legal Representative (Sign): _____ Date: _____

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Please Note: While some of the questions or information requested may be uncomfortable to answer, it is really important to answer all questions and related information. The information that is being requested is due to requirements from the different insurance companies that we work with, as well as for treatment purposes.

CLIENT/PERSON SUPPORTED INFORMATION

Requested Behavior Analyst_____ Date:_____

How Did you Hear About Us?
Referred by: _____ Title:_____
Address: _____ Phone:_____
Website:_____

Reason for seeking ABA services:

_____

_____

Client/Person Supported Name: _____ Sex: _____
Age: _____ Date of Birth: _____ Social Security Number: _____-_____-_____
Address:_____ City_____ St_____ Zip_____
Main Phone#: _____ Alt Phone #:_____ Work Phone #:_____
Occupation: _____ Employer:_____

Please Check:
❑ Caucasian ❑ Hispanic Origin ❑ American Indian or Alaskan Native
❑ African- American ❑ Multi-Racial ❑ Asian or Pacific Islander

Please describe Cultural Values that may impact ABA Treatment:

_____

_____

Religious Affiliation:
❑ Baptist ❑ Catholic ❑ Non-Denominational ❑ Atheist
❑ Methodist ❑ Pentecostal ❑ Spiritual but not religious ❑ Other

Please describe Spiritual Values that may impact ABA Treatment:

_____

_____

FAMILY HISTORY:
Mother: _____ Age: _____ Date of Birth: _____
Social Security Number: _____-_____-_____
Address:_____ City_____ St_____ Zip_____
Main Phone#: _____ Alt Phone #:_____ Email: _____
Occupation: _____ Employer:_____
Medical History (Please list diagnosis if any): _____
Mental Health History (Please list diagnosis if any): _____
Disabilities (Please list diagnosis if any): _____

Father: ______________________________ Age: ________ Date of Birth: ___________________

Social Security Number: _______-_______-_____

Address:___________________________________ City_______________ St_______ Zip__________

Main Phone#: ______________ Alt Phone #:_____________________ Email: ____________________

Occupation: __________________________ Employer:______________________________________

Medical History (Please list diagnosis if any): ____

Mental Health History (Please list diagnosis if any): ____

Disabilities (Please list diagnosis if any): ____

Guardian if not parent:_________________________________ Age: ________ Date of Birth: ____________

Social Security Number: _______-_______-_____

Address:___________________________________ City_______________ St_______ Zip__________

Main Phone#: ______________ Alt Phone #:_____________________ Email: ____________________

Occupation: __________________________ Employer:______________________________________

Medical History (Please list diagnosis if any): ____

Mental Health History (Please list diagnosis if any): ____

Disabilities (Please list diagnosis if any): ____

**If the guardian is not the biological parent, please provide documentation that shows you are the legal guardian and decision maker on behalf of the client.*

Brother/Sister (circle): _______________________________ Age:________ Date of Birth: ____________

Medical History (Please list diagnosis if any): ____

Mental Health History (Please list diagnosis if any): ____

Disabilities (Please list diagnosis if any): ____

Brother/Sister (circle): _______________________________ Age:________ Date of Birth: _____________

Medical History (Please list diagnosis if any): ____

Mental Health History (Please list diagnosis if any): ____

Disabilities (Please list diagnosis if any): ____

Brother/Sister (circle): _______________________________ Age:________ Date of Birth: ____________

Medical History (Please list diagnosis if any): ____

Mental Health History (Please list diagnosis if any): ____

Disabilities (Please list diagnosis if any): ____

Brother/Sister (circle): _______________________________ Age:________ Date of Birth: ________________

Medical History (Please list diagnosis if any): ____

Mental Health History (Please list diagnosis if any): ____

Disabilities (Please list diagnosis if any): ____

School Which Child Attends:____

County (School District):____ Grade_____________

Address:___________________________________ City_______________ ST_______ Zip__________

Main Phone#:_______________ Principle:____________________________ Child's Teacher:___ __________

Is this School (Please Check): ❑ Public ❑ Private ❑ Homeschool ❑ Alternative ❑ Other

Does your child have the following in place at school? (Please Check): ❑ IEP ❑ 504 Plan ❑ Functional Behavioral Assessment (FBA) ❑ Behavior Intervention Plan (BIP) ❑ Other

**If your child has any of the above in place at school, it is being requested that you provide copies of these documents to BOS as well.*

Which of the following applies to your child's attendance at school? (Please Check):

❑ My child attends school FULL-TIME just like other kids their age

❑ My child attends school PART-TIME

❑ **My child arrives later to school each day due to ________________**

❑ **My child leaves school earlier each day due to _________________**

❑ My child only attends school on the following days:________________

❑ My child is on Home-Bound and receives educational services at home

Primary Care Physician/Pediatrician: _____

Name of Clinic: _____

Address:_____ City_____ St_____ Zip_____

Main Phone#: _____ Alt Phone #:_____ Email: _____

Fax:_____

List Medical Problems/Diagnosis	How Treated?
❑ Autism	
❑ ADHD	
❑ Intellectual Disability	
❑ Pervasive Developmental Disorder	
❑ Traumatic Brain Injury	
❑ Other:	

LIST **PREVIOUS** THERAPIES	Dates:	Therapist and Location	What was worked on?	What were the results?
❑ Medication Management				
❑ Psychiatrist				
❑ Counseling				
❑ Applied Behavior Analysis (ABA)				
❑ CCFT				
❑ Occupational Therapy				
❑ Speech Therapy				
❑ Physical Therapy				
❑ Play Therapy				
❑ Other:				

How does the client communicate?	Please Describe in more detail
❑ Nonverbal, may babble but no effective communication	
❑ Grunts, gestures, points	
❑ American Sign Language	
❑ Uses a Communication Device	
❑ Limited vocabulary, Uses 1-3 word phrases	
❑ Complex Speech, no communication problems	

Any Sleep Problem?	Please Describe:	How Treated?

Any Problems with Constipation or Bowel Movements?	Please Describe:	How Treated?

LIST **CURRENT** MEDICATIONS	STRENGTH/DOSAGE	PRESCRIBER:

List any allergies:	What Happened?

List any serious injuries:	Date and how treated.

Placement History/Psychiatric History/Hospitalizations/Significant Events

Start Date or Admission Date:	End Date or Discharge Date:	Location: (include name and address)	Reason:

Addictive Substances History:	Write in Last Use for each
❑ Alcohol—how much/often?	
❑ Tobacco—how much/often?	
❑ Illegal Drugs (Cocaine, LSD, Marijuana, etc.)—how much/often?	
❑ Sugar—list/how much/often?	
❑ Others—list/how much/often?	

Abuse History:	Please Check for each	Please describe:
❑Emotional Abuse?	❑ Suspected ❑ Known	
❑ Verbal Abuse?	❑ Suspected ❑ Known	
❑ Physical Abuse?	❑ Suspected ❑ Known	
❑ Sexual Abuse?	❑ Suspected ❑ Known	
❑ Other-	❑ Suspected ❑ Known	
❑ NO Suspected of Known Abuse		

Has the Department of Children Services (DCS) EVER been involved with your family?
❑ NO ❑ Yes – Describe (include dates):

Have one or more of the children ever been removed from the home by DCS?
❑ NO ❑ Yes – Describe (include dates):

Is there currently a social worker from the Department of Children Services (DCS) that has contact with your family?

❑ NO ❑ Yes – Describe (include the social workers name and contact information):

Please describe custody arrangements of the child:

Are there any legal issues involving the child and/or family that may impact ABA treatment?

Please list the following:

What are your child's MOST FAVORITE FOODS?

What are your child's MOST FAVORITE SNACKS?

Is your child's diet restricted in any way? Will he/she only eat certain foods? If so, please list them here:

What are your child's MOST FAVORITE PLACES TO GO?

What could your child absolutely NOT LIVE WITHOUT? What is/are your child's most favorite things to play with, or do in the "whole wide world?"

Before problem behaviors occur, there are often little warning signs that the person is about to "act out." What are his /her warning signs that occur right before the problem behaviors occur?

Were there major incidents that prompted you to seek behavioral services? If so, please describe and include dates:

_____

_____

_____

_____

_____

_____

_____

What are some of your child's strengths or things he/she is really good at?

_____

_____

_____

_____

What are some of your child's weaknesses or things he/she needs help with?

_____

_____

_____

_____

What do you think contributes to the client engaging in problem behaviors?

_____

_____

_____

_____

What are some goals that you would like to work on through behavioral services?

_____

_____

_____

_____

_____

With keeping in mind that ABA services are in great demand and that appointments are challenging to schedule, please fill out what times each day that you and your child would be available for ABA services in order to help determine the best meeting times. We may or may not be able to accommodate your preferences. Please remember to be flexible in order to give us the greatest chance to meet your needs. Thank you :)

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

- **Please note that night and weekend appointments may, or may not, be able to be arranged based upon the individual schedules of the ABA practitioners.**

Potential High-Risk Behaviors: **Please put a check ☒ beside the problem behaviors that apply to this individual:**	**When did it first start?**	**How Often does this occur per day, week, or month?**	When is it MOST LIKELY to occur?	When is it LEAST LIKELY to occur?
☐ **Self-Injurious Behaviors**- Any action which could hurt oneself by hitting, biting, picking at, slapping, scratching, cutting self, etc.				
☐ **Physical Aggression**- Any action which could hurt others such as hitting, slapping, spitting, biting, throwing things at people, etc.				
☐ **Property Destruction**-Any action which could hurt things by hitting them, throwing them, etc.				
☐ **Elopement-** trying to run away or wander away from supervision.				
☐ **PICA-** any attempt to eat inedible objects such as cigarette butts, grass, raw eggs, etc.				
☐ **Theft-** Any attempt to take items which do not belong to you, or without paying for them.				
☐ **Inappropriate Sexual Behaviors-** Any attempt to have sexual contact with others without their permission				
☐ **Public Exposure-** Stripping or exposing one's self in public areas (common areas of the home or in public places)				
☐ **Medical Complaints-** faking medical situations like seizures, skin conditions, difficulty breathing, blood poisoning, etc. in order to seek medical attention, and if and when a medical assessment has been done, there was nothing medically wrong identified.				
☐ Other (describe):				

Potential Medium to Low Risk Behaviors: Please put a check ☒ beside the problem behaviors that apply to this individual:	**When did it first start?**	**How Often does this occur per day, week, or month?**	When is it MOST LIKELY to occur?	When is it LEAST LIKELY to occur?
☐ **Inappropriate Toileting**-Urinating or having bowel movements anywhere other than in the toilet (such as on self, floor, closet, etc.)				
☐ **Non-Compliance**-refusal to participate in daily activities				
☐ **Temper Outbursts-** Yelling, whining, crying, kicking, taking off shoes and socks and throwing them, dropping to the ground and refusing to move, etc.				
☐ **Verbal Aggression**- Yelling, cussing, threatening to hurt others, threatening to get staff fired, etc.				
☐ **Manipulative Behaviors-** asking several people the same question to get what they want, lying, threatening to hurt themselves if they don't get what they want, etc.				
☐ **Self-Stimulating Behaviors-** making vocal noises repeatedly like "yeeeehing" or other sounds, rocking, pacing, hand to mouth, grinding teeth, hands over ears to block noises, staring at hands in front of face, chewing on blankets and clothing, sniffing things, sniffing people and their feet, crumbling food items and/or pouring drinks just to watch them, "humping," etc.				
☐ **Difficulty with Transitions:** between people places activities, etc.				
☐ **Hallucinations-** interacting with things that others can not see or hear (i.e. talking with people or things that others can not see or hear, etc.)				
☐ **Delusions-** a belief held with strong conviction despite evidence that it is not true (i.e. believing that someone is out to hurt the person although no one is trying to hurt him/her, etc.)				
☐ Other (describe):				

Behavioral Outreach Services, LLC

Phone: 731-446-5441 Email: shiloh.beene@gmail.com Fax: 731-784-2664 https://behavioraloutreach.com

FREQUENTLY ASKED QUESTIONS:

How Often Are ABA Appointments? Once a week, same day and same time each week

How Long Do ABA Appointments Last? Allow 2 hours per visit. Some visits may be shorter or longer depending on what we need to work on. If child has problem behaviors during ABA appointments, we will stay in session and manage them together until child is once again calm and safe for caregiver to transport in vehicle.

Where Do The ABA Visits Take Place? Almost all of the ABA appointments are done at my office location which is currently located inside of the West TN Hearing and Speech Center, 65 Ridgecrest Rd, Jackson, TN 38305. If for whatever reason we are not making progress towards a particular goal, an occasional ABA appointment may take place in the family's home and/or community setting. Just be aware that 99% of the time we are able to accomplish progress towards behavioral goals through ABA visits in office location.

What is the Purpose/Goal of ABA Services? Our ABA services focuses on 1.) preventing problem behaviors, 2.) teaching caregivers how to consistently respond to problem behaviors when they occur so that they are less likely to occur in the future, and 3.) teaching the caregivers HOW to teach the child socially appropriate ways to get child's wants and needs met to "right way."

How are these Goals of ABA Accomplished? The caregivers are given a "behavior book" to write down data. The data sheets are developed based upon the information you report in the Intake Paperwork. The Behavior Analyst will then teach you HOW to record behavior data. **The "behavior book" MUST come with you each week to review during ABA appointments.** It is then the Behavior Analyst's job to pull apart all the information recorded by the caregivers in order to DETERMINE WHY the child is having problem behaviors (Are they for attention? To get things they want? To get out of doing something they know how to do but don't want to do it? To get out of doing something they don't know how to do and they are frustrated? Is the child in pain and not able to indicate that? Is it for sensory stimulation or some other reason?). **Please note, the Behavior Analyst can not do a proper assessment and recommend proper behavioral strategies/treatment unless accurate behavior data is collected by the caregivers and brought to the ABA appointments.**

Who Participates in the ABA Appointments? BOTH the child and parents come back for the ABA appointments. We then discuss what has been going well over the past week, what has not been going well over the past week, and what additional strategies need to be added to what we are already working on in order to further our goals of decreasing problem behaviors and increasing child's appropriate skills to help them get what they want and need. **Please note that we will ONLY add 1-2 behavioral strategies/treatments at a time in order to make sure that the family is successful each and every step of the way during ABA therapy. We want to make sure that you fully understand what to do, how to do it, when to do it, what not to do, etc. before we add another strategy. ABA is WORK and takes a bit of energy on both the parents' and child's part. Since you, the parent, are already using a lot of energy parenting, why not FOCUS that energy is such a way that you are being more efficient and reducing problem behaviors over time. It makes good logical sense.**

Should Us Adults Really Talk About the Child's Problem Behaviors in Front of Them? YES. We, the adults, discuss what has been going well, and what has not been going well. We also include the child in the conversations as appropriate. Discussing this in front of and/or with the child helps them to process the information and know the difference between good decisions/behaviors and bad decisions/behaviors. It also includes them in some decision-making (when it is possible and/or appropriate depending upon what we are working on).

By Recording Problem Behaviors My Child is Having, am I Saying They Are a Bad Kid? NO. Not at all. There are no bad kids, just bad behaviors. GOOD NEWS is we can work with bad behaviors and decrease them over time. If you accurately record behavior data, and consistently use the strategies that we teach you (specifically developed for your child and the reason they are having problem behaviors), it usually works. Just know, like everything else in life, there are no 100% guarantees. We do however have a good success rate, as well as a good satisfaction rate.

Do Problem Behaviors Slowly Get Better or Time, or How Does That Work? Please be aware that once we start implementing new strategies **there will most likely be a TEMPORARY INCREASE in problem behaviors. This is called an "extinction burst" and occurs because the problem behaviors no longer get the child what they want.** The problem behaviors are put on "extinction" while we teach new and socially appropriate ways to get their wants and needs met. By using the behavioral strategies consistently, the increase in problem behaviors is usually short-lived. Expect these temporary increases in problem behaviors to occur every time new behavioral strategies are put in place. Don't worry though because they are usually very short-lived, and are usually not as challenging as time go by. Also note that children will make fast progress in some areas, and slower progress in others. There may even be times where it seems like the child may take "3 steps forward and 2 steps back." This is due to uneven skill development, a child's strengths and weaknesses, caregivers' strengths and weaknesses, and other factors including but not limited to schedules, illness, medications, etc. Not to worry though because progress is progress, and as long as we continue to move in the right direction, we will get there!

If our Child Misses Some School Time Due to ABA Visits, How Do We Get Those Excused? Make sure to remind us to give you a note for school at EVERY ABA appointment in order to excuse the absence. We always give you 2 copies of the note (one for you to keep, and one to give to the school). You can also make sure it is noted in the child's IEP or 504 plan (if they have one) that they leave school early those days for outside ABA therapy.

How Long Does a Child Usually Receive ABA Services Before They Are Discharged From ABA? Each child is different from the next. ABA services may only be needed for 6 months for one child, while another child may require 3 years, etc. A child who is younger may not need ABA for as long as a child that is in their teens and has a long history of having serious problem behaviors for many years. ***Everyone is completely different from each other.*** The length of time that a child receives ABA is completely dependent upon their own unique situation and the progress that is made during ABA. Just be aware that OUR JOB IS TO WORK OURSELVES OUT OF A JOB. Our job is to teach the caregivers the tools that they need to prevent problem behaviors, how to appropriately respond to problem behaviors so that they are less likely to occur over time, and how to teach the child the skills they need in order to be able to get what they want and need "the right way."

What Does Being Discharged from ABA Mean? It means you no longer have weekly ABA appointments and no longer have to collect behavior data (unless you need it to have discussions with other doctors like pediatricians, psychiatrists, etc.). HOWEVER, you DO NOT stop using the behavioral strategies that you have learned and put in place during the course of ABA therapy. If you stop using the behavioral strategies, the problem behaviors are likely to return.

What if Problem Behaviors Start Up Again? You can request ABA services again if needed. You would have to go through the Intake Process again, and get on the waitlist. You can also contact the member services number on the back of your insurance card to get a list of ABA providers that are "in network" with your insurance company **IF** ABA is a "covered benefit" on your insurance policy.

Behavioral Outreach Services, LLC

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY. *This Practice is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care.*

This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when personnel transport patient records to another service location. The information will be maintained under a locked environment at all times (i.e. password protected electronic device, locked vehicle with records out of sight, etc). At no time during transport should the records be accessible by non-personnel. It may be necessary to take client files to a facility where a client is confined or to a client's home where the client is to be examined or treated.

NO CONSENT REQUIRED: The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

(b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the insurance program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(a) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Practice may also use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations –

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect, or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER: The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice:

a) Telephoning the contact number on file and leaving a message on your answering machine or with the individual answering the phone.

b) Texting the contact number on file with the appointment information.

SIGN-IN LOG: The Practice may maintain a sign-in log for individuals seeking care and treatment in the office. Sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS: The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

(b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS: You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c)Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and obtain a copy of your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

(e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy).

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Receive notice of any breach of confidentiality of your PHI by the Practice.

(i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash.

(j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(k) Request copies of your PHI in electronic format.

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Shiloh Beene, at 731-446-5441 or by email at shiloh.beene@gmail.com

PRACTICE'S REQUIREMENTS: The Practice:

- is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- is required to abide by the terms of this Privacy Notice.
- reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- will distribute any revised Privacy Notice to you prior to implementation.
- will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS: You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below that is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer is Shiloh Beene.

You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE: This Notice is in effect as of _10_/_29_/_18_.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Client/Person Supported Name (please print) Date

_____ _____
Parent/Legal Representative (print) Parent/Legal Representative (sign)

THIS FORM WILL BE PLACED IN THE CLIENT/PERSON SUPPORTED'S CHART AND MAINTAINED FOR SIX YEARS.
Please list below the names and relationships of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____