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). **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 (Behavioral Services) with BOS:

- ○ BOS Referral Forms filled out, signed, and returned (All of them)
- ○ Current Copy of ISP
- ○ Reportable Incidents for past year
- ○ If Client/Person Supported had Behavioral Services in the past, we also need the following (by email please):
  - BSAR or Annual Update
  - Behavior Support Plan
  - All Excel graphs for Client
  - Last 12 months of CSMRs (progress reports)

How to get Intake Packet and Required Documents to Us:

1.) Scan in and email to shiloh.beene@gmail.com (preferred method)

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:

1.) Denying any individual any services, opportunity, or **other** benefit for which he or she is otherwise qualified;
2.) 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;
3.) Subjecting any individual to segregated or separate treatment in any manner related to his or her receipt of service;
4.) 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;
5.) Adopting methods of administration that would limit participation by any group of recipients or subject them to discrimination;
6.) Addressing an individual in a manner that denotes inferiority because of race, color, or national origin;
7.) 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.**

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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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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BEHAVIORAL SERVICES ADULT DIDD REFERRAL			
Client/Person Supported Name:	ISP Date:	DOB:	Date Referred:
Street: City: Zip Code:			PHONE: ( )
Funding Source:	Class: SA RO Other		Risk Level: Low Medium High
Conservator/Guardian:	Phone: Fax: Email:		
ISC: Company:	Phone: Fax: Email:		
TennCare Case Manager:	Phone: Fax: Email:		
Provider Agency:	Phone: Fax: Email:		
Contact Person/ Home Manager:	Phone: Fax: Email:		
Personal Completing Referral:	Phone: Fax: Email:		
Psychiatrist: Address:	Phone: Fax: Email:		
Former Behavioral Services: ☐Yes ☐ No Former Behavioral Services Provider: Previous BA:	Phone: Fax: Email:		

If this individual is under the age of 21 have they already been denied services by TennCare? ☐Yes ☐ No

PROBLEM BEHAVIORS - Does this person have behavioral issues that:
(1) place him/her at imminent risk of harm ☐Yes ☐ No (2) have resulted in significant damage to property ☐Yes ☐ No
(3) significantly impairs his/her ability to live in the home or community setting, or participate in normal community activities? ☐Yes ☐ No
If so, has this been documented in the ISP/IEP? ☐Yes ☐ No

Please put a check ☒ beside the problem behaviors that apply to this individual:

Potential High-Risk Behaviors:

☐ **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-** Any attempt 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:

☐ **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
☐ **Threatening Others/Verbal Aggression-** Yelling, threatening to hurt others, threatening to get staff fired, etc.
☐ **Temper Outbursts-** Yelling, whining, crying, kicking, taking off his shoes and socks and throwing them, dropping to the ground and refusing to move, etc.☐
☐ **Manipulative Behaviors-** asking several people the same question until they get the answer 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 his hands in front of his 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):

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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:

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(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.

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(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.

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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.

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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.

________________________ __________________________

________________________ __________________________

________________________ __________________________

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