Endless Potential
5711 Vista Dr. Suite 100 Ferndale, WA 98248
Phone: (360) 746-4092 Fax: 206-483-1370
Email: robyn@endlesspotentialllc.com

Thank you for choosing Endless Potential for ABA!
We look forward to working with your family.

Please complete this intake packet and send the requested documents to robyn@endlesspotentialllc.com or Fax: 206-483-1370

Required for Insurance Authorization:

- ☐ Copy of insurance card.
- ☐ Diagnostic report with the DSM 5 checklist - must be from a designated Center of Excellence.
- ☐ Prescription letter/Order for ABA - must be from the designated Center of Excellence.

Optional to Inform Treatment:

- ☐ Recent professional reports from SLP, OT or PT, if applicable.
- ☐ Copy of current IEP or IFSP, if applicable.
- ☐ Any other documentation or information deemed relevant.

Thanks again for choosing Endless Potential!

Please don't hesitate to reach out if you have any questions.

WHATCOM takingaction for Children and Youth with Special Health Care Needs (CYSHCN)

# Applied Behavioral Analysis (ABA) Intake Form

**Fill out the following intake form and FAX or mail it to any or all of the ABA providers listed on page 1. Keep a copy for yourself. Note the date you sent it to the ABA providers.**

## Child Information

| Last Name: | Today's Date: |
|---|---|
| First Name: | Date of Birth: |
| Middle Name: | Age: years months |
| Home Phone: | Gender: |
| Address: | City: |
| State: Zip: County: | Race/Ethnicity: |

## Child's Primary Health Care Doctor

| Doctor's Name: | Phone: |
|---|---|

## Autism Diagnosis Information

If your child does NOT have an autism diagnosis, but IS on a waiting list or has an appointment for an autism evaluation, please fill out the line below:

No appointment, but on wait list for evaluation with:

Has appointment with: on this date:

If your child HAS an autism diagnosis, please fill out the line below:

| My child was diagnosed by:<br>Phone number of person who diagnosed: | Date of diagnosis: |
|---|---|

## Health Care Coverage Information

Primary Coverage for ABA:

☐ DSHS/DDA/CIIBS Waiver

☐ Apple Health/Medicaid

If so, which plan? ☐ Molina ☐ Community Health Plan of WA ☐ Coordinated Care ☐ United Healthcare Community Plan

☐ Private Health Insurance

If so: Insurance company name:

Please complete the following OR attach a copy of primary insurance card

| Plan Name | Policy # | Group# |
|---|---|---|
| Subscriber (Name of Insured) | | Subscr's DOB |
| Place of employment | | |

| Secondary Coverage for ABA: |
|---|
| ☐DSHS/DDA/CIIBS Waiver |
| ☐ Apple Health/Medicaid |
| If so, which plan? ☐Molina ☐Community Health Plan of WA ☐ Coordinated Care ☐ United Healthcare Community Plan |
| ☐Private Health Insurance |
| If so: Insurance company name: |

| Please complete the following OR attach a copy of secondary insurance card | | |
|---|---|---|
| Plan Name | Policy # | Group# |
| Subscriber (Name of Insured) | | Subscr's DOB |
| Place of employment | | |

## Who has current custody/guardianship of child?

| ☐both parents ☐mother ☐father ☐relative: ☐other: |
|---|
| If there is a parenting plan, please provide a copy. |

## Your availability for ABA appointments (Check all that are possible)

☐ Weekdays, during school hours:

Morning ☐M ☐T ☐W ☐Th ☐F Afternoon ☐M ☐T ☐W ☐Th ☐F

☐ Weekdays, after school hours: ☐M ☐T ☐W ☐Th ☐F

## Mother or Legal Guardian Information

| Full Name: | Relationship to Child: |
|---|---|
| Address: (if different from child) | DOB: |
| | Cell Phone: |
| City: | Home Phone: |
| State: | Business Phone: |
| E-mail: | Occupation: |
| Marital Status: | Employer: |
| General Health: | Education/degree: |

## Father or Legal Guardian Information

| Full Name: | Relationship to Child: |
|---|---|
| Address: (if different from child) | DOB: |
| | Cell Phone: |
| City: | Home Phone: |
| State: | Business Phone: |
| E-mail: | Occupation: |
| Marital Status: | Employer: |
| General Health: | Education/degree: |

## If applicable, please fill in below

| Stepmother's Name: | Phone:(h) (w): |
|---|---|
| Stepfather's Name: | Phone:(h) (w): |

## Emergency Contact

| Full Name: | Phone (h): |
|---|---|
| Relationship to Child: | Phone (w): |

## Other People Living in the Home

| Name: | Relationship: | Age: | Gender: |
|---|---|---|---|
| Name: | Relationship: | Age: | Gender: |
| Name: | Relationship: | Age: | Gender: |
| Name: | Relationship: | Age: | Gender: |

## Other People Significant to your Child NOT Living in the Home

| Name: | Relationship: | Age: | Gender: |
|---|---|---|---|
| Name: | Relationship: | Age: | Gender: |
| Name: | Relationship: | Age: | Gender: |

## Were you referred for ABA by someone?

☐ Yes ☐ No If yes, who:

## What do you want ABA to help with?

## Please describe any behavior issues your child has (e.g., self-injurious, aggressive towards others, etc.) and methods used to decrease behaviors.

## Please describe your child's current communication skills (e.g., sign language, PECS, verbal).

| What else would you like us to know about your child? |
|---|
| |

| If your family has cultural, religious, ethnic or social beliefs about physical or mental health or illness that you feel would help us in understanding your child and family, please describe below. |
|---|
| |

## Current & Previous Services

| Current School/Placement (Type of Special Educational Services) | |
|---|---|
| Name of School: | Years attended: |
| Address: | Placement: |
| Phone: | Hours in school p/wk: |

| Previous Schools/Placements (Type of Special Educational Services) | |
|---|---|
| Name of School: | Years attended: |
| Address: | Placement: |
| Phone: | Hours in school p/wk: |
| Name of School: | Years attended: |
| Address: | Placement: |
| Phone: | Hours in school p/wk: |

| Behavioral Consultation Provider | | | |
|---|---|---|---|
| If your child receives or has received behavioral services, please complete below: | | | |
| Dates of service: to | | Frequency of service: per | |
| Agency: | | Provider Name: | |
| Provider Phone: | | | |
| Please describe services: | | | |
| | | | |
| Please describe the results in achieving goals: | | | |
| | | | |

| If additional behavioral provider, please complete below: | |
|---|---|
| Dates of service: to | Frequency of service: per |
| Agency Name: | Provider Name: |
| Provider Phone: | |
| Please describe services: | |
| | |
| Please describe the results in achieving goals: | |
| | |

## Additional Diagnostic Information

| If your child has other diagnoses, please list below: |
|---|
| |
| |

## Medication Information

Is your child on medication? ☐Yes ☐No

If yes, please list below:

| Medication: | Dosage: | When given: | Used for: | Prescribed by: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please list additional medications on a separate page and attach

## Other medical conditions or allergies

Below, please list medical conditions or allergies that need to be considered when delivering ABA treatment:

| Condition or allergy: | Doctor treating it: | Doctor's specialty: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Supportive Services

Please list other services your child currently receives both in school and out of school. Please enclose a copy of the child's most recent IEP or IFSP and goals from each area checked.

| Service/Therapy: | Location: | Minutes/Week: |
|---|---|---|
| ☐ Early Intervention Services<br>Provider: | ☐ School ☐ Home | |
| ☐ Speech and/or language therapy<br>Provider: | ☐ School ☐ Home | |
| ☐ Occupational Therapy<br>Provider: | ☐ School ☐ Home | |
| ☐ Physical Therapy<br>Provider: | ☐ School ☐ Home | |
| ☐ Vision services<br>Provider: | ☐ School ☐ Home | |
| ☐ Hearing services<br>Provider: | ☐ School ☐ Home | |
| ☐ Psychotherapy/Counseling<br>Provider: | ☐ School ☐ Home | |
| ☐ Other<br>Provider: | ☐ School ☐ Home | |

Please describe the results of these therapies in achieving goals:

## Additional Information

WA State requires that we ask the following questions:

| Has the client ever been admitted to a hospital/treatment center for psychiatric, behavioral, or crisis situations? | |
|---|---|
| ☐Yes ☐No | If yes, please explain below & include discharge documentation: |
| | |

| Does the client have a history of substance use, including tobacco use? | |
|---|---|
| ☐Yes ☐No | If yes, please explain below: |
| | |

| Does the client have a history of gambling or computer gaming? | |
|---|---|
| ☐Yes ☐No | If yes, please explain below: |
| | |

| Is the client an identified risk to themselves or others? Are they suicidal or do they pose a risk of homicide? | |
|---|---|
| ☐Yes ☐No | If yes, please explain below: |
| | |

| Is the client under department of corrections supervision? | |
|---|---|
| ☐Yes ☐No | If yes, please explain below: |
| | |

| Is the client under civil or criminal court ordered mental health or chemical dependency treatment? | |
|---|---|
| ☐Yes ☐No | If yes, please explain below: |
| | |

| Is there a court order exempting the individual participant from reporting requirements? | |
|---|---|
| ☐Yes ☐No | If yes, please provide a copy of the court order. |

# ABA PARTICIPATION AGREEMENT

As parent or legal guardian I hereby agree to the following terms and conditions regarding the intervention to be accorded to the above-named client by Endless Potential. Specifically, in consideration for the client's participation in the Endless Potential intervention program, I understand and agree as follows:

## SUPERVISION AND COUNSELOR DISCLOSURE

Endless Potential provides Applied Behavior Analysis (ABA). ABA is the use of behavior analytic principles and techniques to bring about meaningful and positive change in behavior. Each provider at Endless Potential is individually licensed with the Washington State Department of Health. There are three levels of licensure for ABA in Washington, each providing a specific component of treatment. Licensed Behavior Analysts (LBA) and Licensed Assistant Behavior Analysts (LABA) conduct assessments, develop treatment plans, provide parent guidance and supervise the implementation of treatment goals. Certified Behavior Technicians (CBT) are responsible for the direct implementation of treatment goals under the supervision of a LBA and/or LABA.

By signing below I attest that I've reviewed this disclosure and understand the qualifications of my ABA providers as well as the supervision model utilized for ABA treatment.

## INFORMED CONSENT

**STATEMENT OF AUTHORITY TO CONSENT:** I certify that I have the authority to legally consent to assessment, release of information, and all legal issues involving the above-named client. Upon request, I will provide Endless Potential with proper legal documentation to support this claim. I further hereby agree that if my status as legal guardian should change, I will immediately inform Endless Potential of this change in status and will further immediately inform Endless Potential of the name, address, and phone number of the person or persons who have assumed guardianship of the above-named client.

**TREATMENT CONSENT:** I consent for behavioral treatment to be provided for the above-named client by Endless Potential staff. I understand that the procedures used will consist of manipulating antecedents and consequences to produce improvements in behavior. At the beginning of treatment behavior may get worse in the environment where the treatment is provided (e.g., "extinction burst") or in other settings (e.g., "behavioral contrast"). As part of the behavioral treatment, physical prompting and manual guidance may be used. The actual treatment protocols that will be used have been explained to me. I indemnify and hold harmless Endless Potential as an agency, and its staff members individually from any liability while implementing treatment.

**COMMUNITY CONSENT:** I consent for the above-named client to access community activities with Endless Potential staff. I understand that they will be walking or riding public transportation and that I will be given specific details about where they are going. I understand that I can reach the staff member who is with the above-named client via cellular phone. I indemnify and hold harmless Endless Potential as an agency and its staff members individually from any liability while in the community.

**PHOTOGRAPH/VIDEO/TELEHEALTH CONSENT:** I consent for the above-named client to have his or her photograph taken or a short video recorded to assist with the teaching and learning process of specific treatment goals. I consent to receive treatment via telehealth and understand that these sessions may be recorded for training and supervision purposes.

**COMMUNICATION CONSENT:** I consent for my contact information to be shared with Endless Potential staff for the purpose of scheduling and session planning. Email, texting and cellular phone communications may be used.

**I understand that I may revoke this consent at any time. However, I cannot revoke consent for action that has already been taken. A copy of this consent shall be as valid as the original.**

## LOCATION AND TIME-COMMITMENT OF ABA PROGRAM

Endless Potential's clinic is located at 5711 Vista Dr. Ferndale, WA. Home, school, community, or telehealth sessions will also be provided for parent training, direct services, and social groups.

The above-named client must be available to receive a **minimum of 10-hours/week** of intervention and/or family guidance. The determination of the appropriate number of therapy hours will be made by an initial evaluation by a clinical staff member, and in 6-month reauthorizations thereafter. Generally clients receive 12-20 hours of ABA weekly and parent guidance sessions are required.

Endless Potential does not provide service on the following holidays (which are subject to change): New Year's Day, Martin Luther King Day, Memorial Day, Fourth of July (and the day before or after if it falls on a Tuesday or Thursday), Labor Day, Thanksgiving Day (and the day after), and a week in December around the Christmas holiday.

## ATTENDANCE AND CANCELATION POLICY

I agree to attend at least 90% of all scheduled appointments, including parent guidance meetings. Please provide at least 24-hours notice to cancel an appointment, when possible. More notice for planned absences is greatly appreciated. Cancellation notices of less than 24 hours are considered "late cancellations." Three (3) late cancellations are permitted throughout the duration of an authorization period. Any excessive cancellations will be subject to dropped sessions, fewer hours and/or possible termination from services.

## SICK POLICY

I understand that it is my responsibility to cancel a session if my child is ill (e.g., runny nose, fever, severe congestion, vomiting or diarrhea in the last 24 hours). I acknowledge the importance of not having children participate in intervention when they are ill, due to the risk of contagion among staff and other children served by Endless Potential. I also understand that it is the right of any staff member to terminate a session if they deem the child too ill to continue.

Endless Potential takes the health and safety of our staff very seriously. Please ensure your child is healthy for each session. If they have a fever, cough, sore throat, diarrhea or runny nose please cancel your session immediately. Clients must be symptom free for 24 hours before returning to ABA sessions. If your child exhibits any symptoms during their ABA sessions you will be called to pick them up immediately.

## FAMILY AND/OR CAREGIVER COMMITMENTS

In addition to the terms set forth above, I understand and agree that if the above-named child is a client in this intervention program, my participation in the program is essential and mandatory, and that I will be an important member of the team and will work with the child. I understand that my failure to participate or follow program recommendations might be detrimental to my child's progress. As such, I agree to the following terms:

- **I agree to be accessible by phone during the entire session.**
- I understand and agree that I must have the child prepared for scheduled sessions (e.g. punctual, properly dressed, fed, prepared, etc.).
- **Nut-free lunch, spare clothes, and diapers/wipes (if needed) required daily.**
- If a care provider, grandparent, or other responsible adult is picking up your child we ask that you provide written permission, including their phone number.

- Home-based sessions require a parent or responsible adult to be present during the entire session.
- If my child requires the administration of any medication during the session I agree to administer the medication as EP staff are not permitted to administer medications under any circumstances. If my child has a severe allergic reaction that could require the administration of emergency medication I agree to remain on the premises during the session.
- I agree to work in a collaborative manner with all Endless Potential staff during the course of intervention. I understand and agree that I must, at all times, avoid any actions that might decrease the effectiveness of procedures agreed upon by the child's team. Examples of such actions would be rewarding the child for behaviors that the team has decided to reduce, or providing the child with items that have been limited to specific times or uses (e.g., iPad use or favorite foods). I also agree to remain informed about the child's current program status on a regular basis to demonstrate knowledge of the concepts being taught and in an effort to assist with generalization and consistency across all environments.
- Regularly scheduled parent guidance sessions are required each month. I agree to be present during scheduled parent guidance sessions, or as requested. I also understand that I will be asked to collect specific data on my child's behaviors and will provide this data during these scheduled meetings. I agree to collect accurate and detailed data as specified by the clinical team.

**OTHER CONDITIONS OF PARTICIPATION**

- I understand that staff members may be added, trained, or rotated on or off my child's team at Endless Potential's discretion.
- I understand that it is my responsibility to provide transportation to all activities for my child. Endless Potential staff is not permitted under any circumstances to drive clients to/from any appointments.
- I understand that the Endless Potential staff will call 911 at their discretion in the event of an emergency and that any charges for services incurred by this call would be the responsibility of the client or family.
- I understand that, in addition to providing direct services for children, Endless Potential provides instructional services for professionals, paraprofessionals and parents in the field of behavior analysis. I understand that these professionals, paraprofessionals and parents may participate directly in, observe, or take data on my child's intervention program. All visiting professionals, paraprofessionals and parents will be required to sign a confidentiality agreement, which prohibits their sharing of information about our program whatsoever.
- I understand that the intervention described above might possibly involve the following risk/discomforts: the intervention may be terminated and other more suitable services will be recommended; although the intervention procedures provided are intended to be beneficial, and have helped many children within the autism spectrum in the past, my child might be unchanged or might even have more difficulties after participation in the intervention; my child might experience some distress when staff implements certain procedures (i.e. ignoring inappropriate behaviors).
- I also understand that possible benefits of the program are as follows: my child's overall functioning might improve; I might become a more effective teacher for my child. I might have more time to attend to individual or family needs; Information collected on my child might lead to the improvement of services for other children within the autism spectrum; new personnel will be trained to teach children with autism, and this might lead to the improvement of services for other children within the autism spectrum.
- I understand that, under Washington law, the privilege of confidentiality does not extend to information about sexual or physical abuse of a child. If any member of the program staff is

given or suspects such information, they are required to report it to the authorities. The obligatory report includes alleged or probable abuse as well as known abuse.

- I understand that I may terminate intervention services and withdraw the child from treatment at any time for any (or no) reason. Parents are under no obligation to continue with the program being provided by Endless Potential.
- I understand that Endless Potential may terminate services being provided to the child at any time and for any (or no) reason.
- I understand that Endless Potential will not collaborate with non-evidence based practices when delivering services to clients as in accordance with the BACB ethical code. [In reference to the Behavior Analyst Certification (BACB)-Professional Ethical Compliance Code for Behavior Analysts: 8.0-Public Statements (b) Behavior analysts do not implement non-behavior-analytic interventions.]
- I understand that this agreement supersedes all prior agreements, written or oral, between me and Endless Potential. I acknowledge that I am entering this agreement based on the terms set forth in this agreement, and that no representative of Endless Potential had made any promises, representations, or warranties to me regarding Endless Potential or the intervention services that are not contained in this agreement.
- I understand that Endless Potential is not responsible for the transmission of any contagious pathogen, virus or illness under any circumstances.
- I understand and agree that this Agreement cannot be modified or amended except by means of a written document signed by myself and the Owner of Endless Potential, Robyn Newberry. Any questions I have about the program can be inquired by calling (360) 746-4092 or emailing robyn@endlessotentialllc.com

**FINANCIAL AGREEMENT**

- I understand that it is my responsibility to communicate directly with my insurance provider to ensure that my child has ABA benefits. I am also responsible for all co-insurance, co-pays, denied claims or services that aren't covered by insurance (e.g., no-shows, late-arrivals and/or late pick-up).
- Endless Potential will submit claims directly to insurance for insurance providers that Endless Potential is contracted with only. Endless Potential will appeal denied claims one (1) time only. If claims continue to be denied or insurance continually processes claims incorrectly, the client or responsible party will be required to pay out of pocket for services and must seek reimbursement from their insurance directly.
- Any patient responsibility (coinsurance, copays or any services not covered by insurance, including denied claims or incorrectly processed claims) must be paid within two (2) weeks from receipt of invoice.
- Failure to pay a client account in full within two (2) weeks may result in a hold of services for up to two (2) weeks. If outstanding fees are not paid following the hold period, the client's appointment space will be filled. The client will then be placed at the top of the waitlist for the next open availability.
- I understand that, if placed on the waitlist, direct services may not be available through Endless Potential for up to 6-months. However, administrative staff will make every effort to reinstate services when accounts are paid and/or insurance claims are being processed correctly.

**PRIVACY AND CONFIDENTIALITY**

Washington has taken steps to protect the privacy and confidentiality of patient health information. Health care providers may not disclose a patient's health information to any other person without the patient's written authorization. A patient's authorization must be signed and dated, identify the contents of the disclosure, to whom the disclosure is being made, the person

disclosing the information, and have an expiration date. The law allows patients the ability to revoke the authorization at any time. However, the law does outline exceptions that allow a health care provider to disclose health information without a patient's authorization. Patient authorization is not needed if the disclosure is for the patient's health, health care treatment purposes, payment, or research purposes. Other exceptions include, but are not limited to disclosure to public health officials or to law enforcement. Patients have the right to revoke their authorization for disclosure of confidential medical information at any time in writing. The law imposes a separate requirement on disclosure of minor's' health information. It requires that for disclosure of information contained in a minor's clinical record, the minor's clinical record must be updated to include the circumstances of the disclosure, the persons that received the information, and their relationship to the patient. All communications pertaining to medical treatment between a patient and physician are privileged, and may not be used for trial purposes.

The presumption of health information privacy and confidentiality extends to resident health information in long term care facilities, nursing homes, and enhanced service facilities. Prescription information submitted to the Department of Health must remain confidential, and only be disclosed to pharmacists, providers, law enforcement, and other governmental agencies. The law provides civil, monetary sanctions for individuals who improperly disclose this information. In addition, adverse health event notifications are subject to confidentiality protections. However, the notification of the adverse event itself is subject to public disclosure, including any contextual information the medical facility chose to provide.

Health information that is provided to a health insurance company is also subject to confidentiality provisions under the law. Records held by a health plan cannot be disclosed. Furthermore, the state health insurance pool may not use or disclose personally identifiable data. In addition, records held for and by an independent review committee that investigates insurance denials, are confidential, but must be made accessible to the Insurance Commissioner. Health plans may disclose confidential information in accordance with disclosure laws for providers.

Washington law requires that the state's Department of Health maintain the confidentiality of any individually identifiable data according to state and federal HIPAA standards. Vital records must be kept confidential and secure to prevent unauthorized use. However, vital records may be disclosed for research purposes, as long as there are confidentiality safeguards. The law also protects the confidentiality of certain disease specific information. Generally, the law requires that all reports made for notifiable conditions and diseases that have patient identifying information remain confidential. Tuberculosis reports maintained by local health departments must remain confidential, but may be accessible to the Department. The law also protects HIV and other sexually transmitted disease test results or diagnoses, specifically, from disclosure. The law does provide very limited exceptions for which disclosure is permissible, including to a person who may have been exposed to the disease, health care workers or law enforcement officials who came into contact with the patient, or to public health officials for reporting purposes. The confidentiality laws pertaining to cancer registry information are similar, and allow the information to only be used for statistical, scientific, medical research and public health purposes. The law also provides immunity from liability to individuals who report incidents of cancer to the registry.

State agencies that hold confidential health information may disclose identifying information for research purposes if the patient provides a written request to do so. State agencies may disclose such personal information for research purposes with an individual's consent when certain criteria have been met, such as the disclosure request has scientific merit, the disclosure complies with federal laws and regulations, and the stage agency enters into a confidentiality agreement with the entity conducting the research.

Mental health treatment records are treated separately from other health records under

Washington law. The law allows mental health providers to disclose information regarding a person's involuntary commitment or mental health services provided to a person in custody or in the department of corrections to "authorized persons." However, the fact that a person has received mental health services is confidential, and may only be disclosed under certain circumstances. The law also requires an individual to have access to his or her own mental health treatment records, and has developed procedures allowing individuals to do so. Additionally, Washington has amended the law allowing a patient to release his or her mental health treatment records three times. Primarily the law and its amendments dictate when treatment records may be released without the patient's written consent. According to Washington's rules of construction, each amended provision is valid unless there is a conflict in the purpose of the provisions. If such a conflict exists, then the last filed amendment will control. Washington has separate laws concerning the release of information of a minor's mental health treatment. The law requires that this information remain confidential, and may be disclosed only under certain circumstances. It is a gross misdemeanor under Washington law, to request or access, under false pretenses, confidential information from mental health treatment records.

As an employee, intern, volunteer, group participant or client guardian of Endless Potential I commit to maintain client confidentiality in accordance with state and federal (HIPPA) confidentiality requirements as indicated by my signature below.

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE OF PRIVACY PRACTICES

*This notice describes how protected health information about a client may be used and disclosed and how the client can gain access to this information. Please review it carefully.*

Endless Potential, LP understands that we collect private and/or potentially sensitive medical information about each client and/or the client's family. We call this information "protected health information." This notice explains the client's privacy rights and addresses how Endless Potential, LP may use and disclose protected health information. Endless Potential, LP does not use or disclose protected health information unless permitted or required to do so by law. Endless Potential, LP must adhere to laws aimed at securing the privacy of the client's protected health information. These laws are known as the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. When we do use or disclose protected health information, we will make every reasonable effort to limit its use or the level of disclosure to the minimum we deem necessary to accomplish the intended purpose. Please note that the privacy provisions articulated in this notice do not apply to health information that does not identify the client or anyone else. For more information on Endless Potential, LP privacy practices, or to receive another copy of this notice, please contact: Endless Potential, LP 5711 Vista Dr. Suite 100 Ferndale WA 98248. Phone: (360) 746-4092 Email: robyn@endlesspotentialllc.com Endless Potential, LPis required by law to follow the terms set forth in this notice. We reserve the right to change this notice. If we make a change in our privacy policies or procedures, we will provide the client with a new privacy notice either by mail or in person.

## PROTECTED HEALTH INFORMATION

Protected health information is information about the client that relates to a past, present, or future mental health condition, or treatment or payment for the treatment that can be used to identify the client. This includes any information, whether oral or recorded in any form, that is created or received by Endless Potential, LP. This also includes electronic information and information in any other form or medium that could identify the client. Examples of information that can identify a client include, but are not limited to the following: Client's Name, Telephone Number, Address, Date of Birth, Social Security Number, Service Start/End Date, Diagnosis

## USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE

The following section describes different ways that we use and disclose protected health information for treatment, payment, and health care operations. Not every possible use or disclosure will be noted, and there may be incidental disclosures that are a byproduct of one the listed uses and disclosures. The ways we use and disclose protected health information will fall within one of the categories.

a. Treatment

We may use a client's protected health information to provide the client with services, and we may disclose this information to any and all Endless Potential, LP staff involved with the client's treatment. Treatment includes (a) activities performed by Endless Potential, LP personnel in the course of providing service to the client or in coordinating or managing the client's service with other service providers and (b) consultations with and between Endless Potential, LP staff and other professionals involved in the client's treatment.

b. Payment

We may use and disclose the client's protected health information so that we may bill and collect payment from the client, an insurance company, or another party for services that Endless Potential, LP provides to the client. We may also inform the client's health plan provider of the treatment we intend to administer in order to obtain prior approval or to determine whether the client's plan will pay for the treatment.

c. Health Care Operations

Endless Potential, LP may use and disclose the client's protected health information in order to maintain necessary administrative, education, quality assurance, and business functions. For example, we may use a client's protected health information to evaluate the performance of our staff in providing treatment for the client. We may also use information about clients to help us evaluate what additional services to offer, how we can improve efficiency, or the effectiveness of certain treatments. Additionally, we may use protected health information for review, analysis, and other teaching and learning purposes.

## SPECIAL CIRCUMSTANCES

Treatment, payment, and health care operations further include the circumstances listed below.

a. Appointment Reminders

We may use and disclose the client's protected health information to contact the client as a reminder that he/she may have an appointment for treatment or services.

b. Treatment Information

We may use and disclose the client's protected health information to contact him/her about treatment information.

c. Satisfaction Surveys

We may use and disclose the client's protected health information to contact him/her about Endless Potential satisfaction surveys.

## USES AND DISCLOSURES YOU CAN LIMIT

a. Endless Potential, LP Practice Management

Unless the client notifies us that they object, we may include certain information about them in Endless Potential, LP Practice Management software in order to respond to inquiries and disseminate information more efficiently. This software is accessed by Endless Potential, LP staff who may or may not be involved in the client's treatment.

b. General Notification

Unless the client notifies Endless Potential of objection, we may provide their protected health information to individuals such as the client's family members, caregivers, and friends, who are

involved in the client's treatment or who help pay for the client's treatment. We may do this if the client informs us that we have their consent to do so, or if the client knows we are sharing the client's protected health information with these people and the client expresses no objection or makes no reasonably discernible attempt to prevent us from doing so. There may also be circumstances when we can assume, based on our professional judgment, that the client would not object to disclosure of their protected health information. Also, if the client is not able to approve or object to disclosures, we may make disclosures to a particular individual (such as a client's family member or friend), that we feel are in the client's best interests and that relate to that person's involvement in the client's care.

## OTHER PERMITTED USES AND DISCLOSURES OF HEALTHCARE INFORMATION

We may use or disclose the client's health information without the client's permission in the following circumstances, subject to all applicable legal requirements and limitations:

a. Required By Law

Endless Potential, LP must make any disclosures required by federal, state, or local law. These may include, but are not limited to, disclosures pertaining to: the reporting of abuse or neglect; court orders, subpoenas, warrants, or other lawful processes; identification/location of a suspect, fugitive, witness, missing person, or crime victim; crime on our work premises; or a serious, imminent threat. Employees of Endless Potential, LP are designated as Mandated Reporters.

b. Public Health Risks

We may make disclosures for public health reasons in order to prevent or control disease, injury, or disability; or to report births, deaths, disease or condition, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

c. Health Oversight Activities

We may disclose protected health information to agencies authorized to receive reports for health oversight activities (e.g., Department of Health and Human Services, Office of the Attorney General) for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.

d. Lawsuits, Disputes, or Other Legal Proceedings

We may make disclosures in response to a subpoena or court or administrative order, if the client is involved in a lawsuit or a dispute, or in response to a court order, subpoena, warrant, summons or similar process, or if requested to do so by law enforcement.

e. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose information to a coroner or medical examiner, (as necessary, for example to identify a deceased person or determine cause of death) or to a funeral director, as necessary to allow them to carry out their activities.

f. Research

We may use or disclose protected information for research purposes under certain limited circumstances. Research projects are subject to approval by an institutional review board. Therefore, we will not use or disclose the client's protected health information for research purposes until the particular research project, for which the client's information may be used or disclosed, has been approved through the institutional review board.

g. Serious Threat to Health or Safety; Disaster Relief

We may disclose information to appropriate individual(s)/organization(s) when necessary (a) to prevent a serious threat to the client's health and safety or that of the public or another person, or (b) to notify the client's family members or persons responsible for the client in the course of a disaster relief effort. We will disclose protected health information only to persons we believe to be able to lessen/prevent the threat and will limit disclosure to that which we deem necessary

to lessen or prevent the threat.
h. Military and Veterans
We must make disclosures as required by military command or other government authority for information about a member of the domestic or foreign armed forces.
i. National Security; Intelligence Activities; Protective Services
We may disclose information to federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.
j. Correctional Facilities
We may make disclosures to a correctional facility (if the client is a ward) or a law enforcement official (if the client is in that person's custody) as necessary (a) for the institution to provide the client with treatment; (b) to protect the client's or others' health and safety and the security of the correctional facility.

**MANDATED REPORTING LEGAL REQUIREMENTS**

**Endless Potential clinical staff are mandated reporters, required by law to report suspected child abuse or neglect to the authorities. If child abuse or neglect is suspected client information will be shared with Child Protective Services.**

**WHEN WRITTEN AUTHORIZATION IS REQUIRED**

Other than for the range of purposes previously identified in this notice, we will not use or disclose the client's protected health information for any purpose unless the client provides us with specific written authorization to do so. If the client grants us authorization, the client can still withdraw this authorization at any time, though the authorization must be evoked in writing. In order to withdraw the authorization, the client must deliver, mail, email, or fax the revocation to the Owner of Endless Potential, LP, Robyn Newberry to:

Address: 5711 Vista Dr. Suite 100 Ferndale, WA 98248
Phone: (360) 746-4092 Fax: (206) 483-1370 Email robyn@endlesspotentialllc.com

If the client revokes the authorization, we will discontinue the use or disclosure of the client's protected health information to the extent that we relied on his/her authorization for the use/disclosure. However, we cannot take back or undo any use/disclosure made under the client's grant of authorization prior to our receipt of the client's written revocation of that authorization, and we must continue any use/disclosure that is necessary in keeping records of the client's treatment.

**CLIENT INDIVIDUAL RIGHTS**

**WAC 388-877-0600 Clinical - Individual rights:**

(1) Each agency licensed by the department to provide any behavioral health service must develop a statement of individual participant rights applicable to the service categories the agency is licensed for, to ensure an individual's rights are protected in compliance with chapters 71.05, 71.12, and 71.34 RCW. In addition, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:"

(a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;

(b) Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;

(c) Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate,

limited-English proficiency, and cultural differences;

(d) Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;

(e) Be free of any sexual harassment;

(f) Be free of exploitation, including physical and financial exploitation;

(g) Have all clinical and personal information treated in accord with state and federal confidentiality regulations;

(h) Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;

(i) Receive a copy of agency grievance system procedures upon request and to file a grievance with the agency, or behavioral health organization (BHO), if applicable, if you believe your rights have been violated; and

(j) Lodge a complaint with the department when you feel the agency has violated a WAC requirement regulating "behavioral health agencies."

(2) Each agency must ensure the applicable individual participant rights described in subsection (1) of this section are:

(a) Provided in writing to each individual on or before admission;

(b) Available in alternative formats for individuals who are visually impaired;

(c) Translated to the most commonly used languages in the agency's service area;

(d) Posted in public areas; and

(e) Available to any participant upon request.

(3) Each agency must ensure all research concerning an individual whose cost of care is publicly funded is done in accordance with chapter 388-04 WAC, protection of human research subjects, and other applicable state and federal rules and laws.

(4) In addition to the requirements in this section, each agency providing services to medicaid recipients must ensure an individual seeking or participating in behavioral health treatment services, or the person legally responsible for the individual is informed of their medicaid rights at time of admission and in a manner that is understandable to the individual or legally responsible person.

(5) The grievance system rules in WAC 388-877-0654 through 388-877-0675 apply to an individual who receives behavioral health services funded through a federal medicaid program or sources other than a federal medicaid program.

[Statutory Authority: RCW 71.24.870, 70.02.290, 70.02.340, 71.05.560, 71.24.035, and 71.34.380. WSR 18-06-043, § 388-877-0600, filed 3/1/18, effective 4/1/18. Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-877-0600, filed 6/15/16, effective 7/16/16. Statutory Authority: Chapters 70.02, 70.96A, 71.05, 71.24, 71.34, 74.50 RCW, RCW 74.08.090, 43.20A.890, and 42 C.F.R. Part 8. WSR 13-12-054, § 388-877-0600, filed 5/31/13, effective 7/1/13.]

**WAC 388-877-0680 Individual rights specific to medicaid recipients:**

(1) Medicaid recipients have general individual rights and medicaid-specific rights when applying for, eligible for, or receiving behavioral health services authorized by a behavioral health organization (BHO).

(a) General rights that apply to all individuals, regardless of whether an individual is or is not a medicaid

recipient, include:

(i) All applicable statutory and constitutional rights;

(ii) The participant rights provided under WAC 388-877-0600; and

(iii) Applicable necessary supplemental accommodation services listed in chapter 388-472 WAC.

(b) Medicaid-specific rights that apply specifically to medicaid recipients include the following. You have the right to:

(i) Receive medically necessary behavioral health services, consistent with access to care standards adopted by the department in its managed care waiver with the federal government. Access to care standards provide minimum standards and eligibility criteria for behavioral health services and are available on the behavioral health administration's (BHA) division of behavioral health and recovery (DBHR) website.

(ii) Receive the name, address, telephone number, and any languages offered other than English, of behavioral health providers in your BHO.

(iii) Receive information about the structure and operation of the BHO.

(iv) Receive emergency or urgent care or crisis services.

(v) Receive post-stabilization services after you receive emergency or urgent care or crisis services that result in admission to a hospital.

(vi) Receive age and culturally appropriate services.

(vii) Be provided a certified interpreter and translated material at no cost to you.

(viii) Receive information you request and help in the language or format of your choice.

(ix) Have available treatment options and alternatives explained to you.

(x) Refuse any proposed treatment.

(xi) Receive care that does not discriminate against you.

(xii) Be free of any sexual exploitation or harassment.

(xiii) Receive an explanation of all medications prescribed and possible side effects.

(xiv) Make a mental health advance directive that states your choices and preferences for mental health care.

(xv) Receive information about medical advance directives.

(xvi) Choose a behavioral health care provider for yourself and your child, if your child is under thirteen years of age.

(xvii) Change behavioral health care providers at any time for any reason.

(xviii) Request and receive a copy of your medical or behavioral health services records, and be told the cost for copying.

(xix) Be free from retaliation.

(xx) Request and receive policies and procedures of the BHO and behavioral health agency as they relate to your rights.

(xxi) Receive the amount and duration of services you need.

(xxii) Receive services in a barrier-free (accessible) location.

(xxiii) Receive medically necessary services in accordance with the early periodic screening, diagnosis, and treatment (EPSDT) under WAC 182-534-0100, if you are twenty years of age or younger.

(xxiv) Receive enrollment notices, informational materials, materials related to grievances, appeals, and administrative hearings, and instructional materials relating to services provided by the BHO, in an easily understood format and non-English language that you prefer.

(xxv) Be treated with dignity, privacy, and respect, and to receive treatment options and alternatives in a manner that is appropriate to your condition.

(xxvi) Participate in treatment decisions, including the right to refuse treatment.

(xxvii) Be free from seclusion or restraint used as a means of coercion, discipline, convenience, or retaliation.

(xxviii) Receive a second opinion from a qualified professional within your BHO area at no cost, or to have one arranged outside the network at no cost to you, as provided in 42 C.F.R. Sec. 438.206 (b)(3)(2015).

(xxix) Receive medically necessary behavioral health services outside of the BHO if those services cannot be provided adequately and timely within the BHO.

(xxx) File a grievance with the behavioral health agency or BHO if you are not satisfied with a service.

(xxxi) Receive a notice of adverse benefit determination so that you may appeal any decision by the BHO that denies or limits authorization of a requested service, that reduces, suspends, or terminates a previously authorized service, or that denies payment for a service, in whole or in part.

(xxxii) File an appeal if the BHO fails to provide services in a timely manner as defined by the state.

(xxxiii) Request an administrative (fair) hearing if your appeal is not resolved in your favor or if the BHO does not act within the grievance or appeal process time frames described in WAC 388-877-0660 and 388-877-0670.

(xxxiv) Request services by the behavioral health ombuds office to help you file a grievance or appeal or request an administrative hearing.

(2) A behavioral health agency licensed by the division of behavioral health and recovery (DBHR) that provides DBHR-certified mental health services, DBHR-certified substance use disorder services, or both, must ensure the medicaid rights described in subsection (1)(b) of this section are:

(a) Provided in writing to each medicaid recipient, and if appropriate, the recipient's legal representative, on or before admission;

(b) Upon request, given to the medicaid recipient in an alternative format or language appropriate to the recipient and, if appropriate, the recipient's legal representative;

(c) Translated to the most commonly used languages in the agency's service area; and

(d) Posted in public areas.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.24.520, 71.34.380 and 42 C.F.R. 438 Subpart F, as amended in 81 Fed. Reg. 27498, May 6, 2016. WSR 17-20-006, § 388-877-0680, filed 9/21/17, effective 10/22/17. Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-877-0680, filed 6/15/16, effective 7/16/16.]

## CLIENT'S RIGHTS REGARDING CLIENT HEALTH INFORMATION

The client has certain rights regarding his/her health information, which are listed below. In each of these cases, if the client wants to exercise their rights, the client must do so in writing by completing a form that the client can obtain Endless Potential, LP. In some cases, we may charge the client for the costs of providing materials to the client. The client can obtain information regarding their rights and any costs that we may charge for materials by contacting the Owner of Endless Potential, LP. Address: 5711 Vista Dr. Suite 100 Ferndale, WA 98248 Phone: (360) 746-4092 Email robyn@endlesspotentialllc.com.

1. Right to Inspect and Copy

With some exceptions, the client has the right to inspect and get a copy of the client's protected health

information that may be used to make decisions about the client's care. We may deny the client's request to inspect and/or copy information in certain limited circumstances, and, if we do this, the client may ask that the denial decision be reviewed.

2. Right to Amend

The client has the right to amend his/her health information maintained by Endless Potential, LP, or used by us to make decisions about the client. We will require that the client provide a reason for the request, and we may deny the request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment), (b) is not part of the health information that we keep, (c) is of a type that the client would not be permitted to inspect and copy, or (d) is already accurate and complete.

3. Right to an Accounting of Disclosures

The client has the right to request an accounting of disclosures. An accounting is a list of certain disclosures we made regarding the client's protected health information. The list does not include all disclosures. For example, it does not include disclosure to the client, disclosure for treatment, payment, and health care operations purposes described above, or disclosure made with the client's authorization as described above.

4. Right to Request Restrictions

The client has the right to request a restriction or limitation on the health information we use or disclose about the client (a) for treatment, payment, or health care operations, or (b) to someone who is involved in the client's care or the payment for it, such as a family member or friend. We are not required to agree to the client's request. Any time Endless Potential, LP agrees to a restriction, it must be in writing and signed by Robyn Newberry, or her designee.

5. Right to Request Confidential Communications

The client has the right to request that we communicate with the client about health matters in a certain method or at a certain place. For example, the client can ask that we only contact the client at home or by mail.

6. Right to a Paper Copy of This Notice

The client has the right to a paper copy of this notice, whether or not the client may have previously agreed to receive that notice electronically.

## QUESTIONS OR CONCERNS

If the client has any questions about this notice they should contact:
Endless Potential, LP Address: 5711 Vista Dr. Suite 100 Ferndale, WA 98248 Phone: (360) 746-4092 Email robyn@endlesspotentialllc.com.

If the client believes their privacy rights have been violated, the client may file a complaint with Endless Potential using the contact information provided above or with the Secretary of the Department of Health and Human Services. To file a complaint with the Secretary of the Department of Health and Human Services, call (877) 696-6775. If the client believes their privacy rights have been violated, contact: Office of Civil Rights, Medical Privacy Complaint Division U.S. Department of Health and Human Services 200 Independence Avenue, S.W. HHH Building, Room 509H Washington, D.C. 20201 Phone: (866) OCR-PRIV (627-7748) TTY: (886) 788-4989 Website: www.hhs.gov/ocr The client will not be penalized for filing a complaint and the client will continue to have the same access to Endless Potential, LP services.

## ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF ENDLESS POTENTIAL, LP NOTICE OF PRIVACY PRACTICES. IF FURTHER ACKNOWLEDGE THAT I HAVE REVIEWED AND UNDERSTAND THE INFORMATION PRESENTED IN THIS NOTICE, INCLUDING THE APPROPRIATE CONTACT INFORMATION FOR THE PARTY(IES) I SHOULD CONTACT IN THE EVENT THAT I HAVE ANY FURTHER QUESTIONS, CONCERNS, REQUESTS, OR COMPLAINTS REGARDING ANY OF THE COVERED SUBJECT MATTER.

**SIGNATURES**

I, _________________________, parent or guardian of __________________________ hereby state that I have read, understand, and agree to the conditions set forth in this participation agreement. I acknowledge that I have been provided with a copy of this agreement. I understand that adherence to the contract regulations is a condition of my child's entrance to the Endless Potential's ABA program and continued participation therein. I further understand and agree that any breach of this contract might result in the termination of services with Endless Potential.

| Signature of Legal Guardian: | Date: |
| --- | --- |
| Relationship to Client: | |
| Client Signature (if over 13 years): | Date: |