Insurance Intake Form

Member Information

Name: _____

Address: _____City: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Best Number to contact: ☐ Home ☒ Work ☐ Cell

Date of Birth: _____ Social Security Number: _____

Responsible/Insured Party

Name: _____

Relationship to Consumer: ☐ Self ☐ Parent ☐ Other _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Best Number to contact: ☐ Home ☒ Work ☐ Cell

Date of Birth: _____ Social Security Number: _____

Employer Name: _____

Insurance Information

Insurance Company: _____

Type of Plan: ☐ HMO ☐ PPO

Name of Medical Group/IPA (if HMO): _____

Insurance Company/ Medical Group Phone (see back of card): _____

Member ID Number: _____ Group Number: _____

**Please make a copy of both front and back of your insurance cards and attach with the form.*

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Secondary Insurance Company: _____

Type of Plan: ☐ HMO ☐ PPO

Name of Medical Group/IPA (if HMO): _____

Insurance Company/ Medical Group Phone (see back of card): _____

Member ID Number: _____ Group Number: _____

**Please make a copy of both front and back of your insurance cards and attach with the form.*

Assignment of Insurance Benefits and Medical Information Release Authorization

Member Name: _____ Date: _____

Insurance Benefits: I authorize the release of information necessary to process any claim. I certify the information I supply is true and correct to the best of my knowledge. I authorize payment of medical benefits to be made on my behalf to ABA Plus Inc. I authorize photocopies of this form to be valid as the original.

Consent to Treat: I authorize applied behavior analysis procedures to be used to treat the member named above at the direction of ABA Plus Inc.

Release of Medical Information

I authorize ABA Plus Inc to release medical information (including chart notes, reports, and assessments) to my primary care physician and/or specific healthcare provider requesting such information in regard to my healthcare.

I also authorize ABA Plus Inc. to release confidential medical information, on my behalf to my insurance carriers and their employees in order to evaluate my insurance, reimbursement, and coverage for office visits and treatment and also may contact my employer and/or medical provider(s), to complete my request for payment.

I assert that I am a legal adult of 18 years of age and that if I am signing for a minor I am a legal guardian of the identified minor. I authorize ABA Plus Inc. to release medical information over the telephone to the following:

_____ Myself only

_____ Listed person in my household: _____

_____ Information may be left on voicemail at this number: _____

I acknowledge that I have read and agreed to be bound by the terms and office policies stated above in areas of the Assignment of Insurance Benefits and Medical Information Release Authorization. The duration of this authorization is for 1 year from the date of the signature or until it is revoked in writing.

Member or Member Legal Guardian's Signature: Date:

Acknowledgement of Receipt of Notice of Privacy Practices

Name:

Address (City/State/Zip):

☐ I have received, read, and understood the Notice of Privacy Practices

_____ _____ _____

Name Signature Date

Relationship, if other than member ☐ Parent ☐ Spouse ☐ Sibling ☐ Guardian

Other (Specify): _____

☐ Member refuses, or is unable, to acknowledge receipt of the Notice of Privacy Practices

_____ _____ _____

Staff Name: Staff Signature Date

Notice of Privacy Practices
This Notice Describes How Medical Information About You or Your Child May Be Used and Disclosed and How You Can Get Access to This Information. Please Review This Notice Carefully.

The Health Insurance Portability Act of 1996 ("HIPAA") is a federal program that protects the privacy of your health care records and requires that all health care providers maintain confidentiality of medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, paper, or orally. The Act gives you the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

Summary of Rights and Obligation Concerning Health Information

ABA Plus INC. ("ABA Plus") is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by ABA Plus. Each time we visit, we make a record. Typically, the record contains you or your child's symptoms, examinations and test results, our assessment of his or her condition, a record of his or her treatment interventions, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances.

You have the right to request restrictions on uses and discloses of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

1. You have the right to reasonable request to receive confidential communication of protected health information in a private and confidential manner, when feasible and upon request. For example, you may want to be contacted at an alternative telephone number.
2. You have the right to inspect and obtain copies of your protected health information. Requests must be made in writing and an appropriate charge may be assessed for each page copied.
3. You have the right to request a change to your medical information if you believe there is an error. You must submit a request in writing; including the information you believe should be changed and we will change your record, if appropriate. We reserve the right to deny the request to change your record, if the change is not appropriate.
4. You have the right to receive an accounting of disclosures of protected health information, except disclosures made for the purpose of treatment, payment, and health care operations. Request must be made in writing. You may receive one listing per calendar year without charge; any additional listings may be subject to a reasonable fee.
5. You have the right to obtain a paper copy of this notice from us upon request.

This Notice Applies To

This notice applies to all facilities and entities owned, operated and/or managed by this practice. A complete listing of facilities and entities operating under this notice may be obtained by contacting the Privacy Office at (818) 855-1490.

This notice describes the practice of this office and those of:

1. Any healthcare professionals authorized to enter information into your record;
2. Any employee, staff and other office personnel, and
3. Any volunteers, interns, or students we allow to work with you while you are a member of this practice.

The Duties of this Office/Organization

This office/organization is required by law to maintain the privacy of your personal medical information and to provide you with notice of our legal duties and privacy practices with respect to that information. We are also required to abide by the terms of our current Notice of Privacy Practices.

Use and Disclose of Medical Information

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your information and how we may use and disclose your health information. We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operations.

1. Treatment means providing, coordinating, or managing health care and related services by one or more providers to assist in treating you;
2. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing and collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment; and
3. Healthcare operations include: business aspects of running our practice, such as conducting quality assessments and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also release confidential medical information to your insurance carriers, to review and assess your insurance, reimbursement, and coverage for office visits and related procedures. We may release confidential medical information to your insurance carriers and their employees that we contact on your behalf, for this purpose. Such information may include your name, age, sex, medical diagnosis, insurance identifiers, employers, or medical providers you identify.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We May Disclose You or Your Child's Medical Information

We may use or disclose your child's medical information in the following ways:

1. Treatment. We may use and disclose your child's protected health information to provide, coordinate, and manage your child's care;
2. Payment. Ewe may use and disclose your health information so that we may bill and collect payment for the services that we provided to your child;

3. Health Care Operations. We may use and disclose your health information to assist in the operation of our practice;
4. Students. Students/interns in health service related programs work in our facility from time to time to meet their educational requirements or to get health care experience. These students may observe or participate in your treatment or use your health information to assist in their training. You have the right to refuse to be examined, observed, or treated by any student or intern. If you do not want a student or intern to observe or participate in your care, please notify your provider.
5. Business Associates. ABA Plus Inc sometimes contracts with third-party business associates for service. To protect your health information, however, we require our business associates to appropriately safeguard your information;
6. Appointment Reminders. We may use and disclose information in your medical record to contact you as a reminder that you have an appointment. We usually call you at the home and/or the cell phone number provided the day before your appointment and leave a message for you on your

answering machine or with an individual who responds to our telephone call. However, you may request that we call you only at a certain number or that we refrain from leaving messages and we will endeavor to accommodate all reasonable requests;

7. Treatment Options. We may use and disclose your child's health information in order to inform you of alternative treatments.
8. Release to Family/Friends. Our staff, using their professional judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, your child's health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law;
9. Health-Related Benefits and Services. We may use or disclose health information to tell you about health-related benefits or services that may be of interest to you. In face-to-face communications, such as appointments with your provider, we may tell you about other products and services that may be of interest to you;
10. Public Health Activities. We may disclose medical information about your child for public health activities. Notifications to appropriate government authorities if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will make this disclosure when required by law, or if you agree to the disclosure or when authorized by law and in our professional judgement disclosures is required to prevent serious harm;
11. Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
12. Law Enforcement. We may release your health information: in response to a court order, subpoena, warrant, summons, or similar process of authorized under state or federal law;
13. Personal Representative. If you or your child has a personal representative, such as a legal guardian, we will treat that person as if that person is your child with respect to disclosure of his or her health information. If your child becomes deceased, we may disclose health information to an executor or administrator of his or her estate to the extent that person is acting as his or her personal representative.

Appointment Reminder, Call Backs, and Treatment Alternatives

We may 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.

Other Disclosures

There are some disclosures of medical information that do not require your authorization. Those disclosures include any of the following:

1. Those required by federal, state, or local law;

2. About victims of abuse, neglect, or domestic violence;
3. To comply with government oversight activities, such as audits or investigations;
4. For judicial or administrative proceedings;
5. For law enforcement purposes, such as in the course of a crime investigation or location of a missing person;
6. For specialized government functions, such as intelligence counter-intelligence, or other national security activities; and
7. For worker's compensation.

Any other uses and disclosures will be made with only your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

For More Information or To Report a Problem

If you have any questions about this Notice, please contact our Privacy Officer at 818-855-1490.

If you believe that we have violated your right to privacy, you may file a formal complain to the Privacy Officer at 818-855-1490, or to the Secretary of U.S. Department of Health and Human Services. There will be no retaliation for filling a complaint.

We reserve the right to change our health information practices and the terms of our Notice of Practices, and to make the changes effective for all protected health information we maintain, including health information created or received before the effective date of the changes. In the event we change our health information practices, we will post and/or personally provide a revised Notice of Privacy Practices.

Effective Date:

This notice is effective as of January 1, 2018

Two-Way Release of Information Form

_____ 1,, (parent/legal guardian) give written consent to "ABA Plus INC" (ABA Plus) and its staff and officers to perform an assessment/re-assessment as well as coordinate the behavioral health care of my son/daughter _____at his/her school or other community/work environments for the purpose of supporting my son/daughter's behavior health treatment plan. I also give permission for BSS to exchange verbal and written information including electronic communication such as e-mails with the following entities including Medical Managed Care Plan/Commercial Health Insurance, Regional Center, School, Work, physicians, nurses, speech therapist, OT, psychologist, and psychiatrist to be released for purpose of coordination of care.

Medical Managed Care Plan:	Phone #
Commercial Health Insurance:	Phone #
Regional Center (specify which):	Phone #
Primary Care Physician:	Phone #
School Personnel:	Phone #
Psychologist/Psychiatrist:	Phone #
Speech Therapist:	Phone #
Other	Phone #

_____ _____

Parent Name Parent Name

_____ _____

Signature Signature

_____ _____

Date Date