Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

PATIENT REGISTRATION

Child: Last Name: _____ First Name: _____ MI: _____

D.O.B.: __ /__ /__ Age: ____ Sex: __ Primary Language: _____

Ethnicity: _____ Religion: _____

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____

Insurance Carrier: _____ ID # _____

Secondary

Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____

Insurance Carrier: _____ ID #_____

Mailing Address: _____

(Street or PO Box) (City) (State & Zip)

Phone: (_____) _____ - _____ Email Address: _____

Who lives at this household? _____

Caregiver /Contact 1: Name: _____ Relation to Patient: _____

Lives with patient? NO Date of Birth: ____ / ____ / ____ Social Security #: ____ - ___ - _____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

Caregiver/ Contact 2: Name: _____ Relation to Patient: _____

Lives with patient? YES Date of Birth: ____ / ____ / ____ Social Security #: ____ - ___ - _____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

If parents are divorced or separated please fill out this section: If not applicable write N/A and sign

Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to therapy? treatment for the child or from obtaining information about the child's therapy treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.
_____

Emergency Contacts, other than parents: Name & Relationship

1: _____/_____ Phone: (_____) _____ - _____

2: _____/_____ Phone: (_____) _____ - _____

If submitting electronically, your typed full name below serves as signature.

_____ _____

Signature of Parent/Legal Representative **Date**

_____ _____

State relationship if other than parent **Signature of Witness** *

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

INSURANCE POLICY

1. All insurance recipients must present their current insurance card at the time of initial service. If you do not have your insurance card you will be considered a self-pay patient.
2. If you have insurance that is primary with Medicaid as secondary, you must provide this information at the time of service. If you fail to disclose your primary insurance, your claim will be denied.
3. Patient/Guarantor will be responsible for all charges incurred if no insurance card is presented or if any amount not paid or covered by their insurance. Services not covered by your insurance company will be due at the time of service. It is your responsibility to know what is covered and what is not.
4. Please notify our office if there are any changes in your insurance coverage or change of insurance of carriers.

This is to certify that I (we) the undersigned, voluntarily consent to the administration of the practice of diagnostic procedure/imaging/photography and therapy treatment by providers, authorized agents and employees of the practice as may, in their professional judgment be deemed necessary or beneficial. Unless otherwise specified, all healthcare providers may obtain additional consents for individual procedures. I (we) acknowledge that no guarantees have been made to me (us) as to the effect of such examination or treatment. I understand that the insurance benefits are provided directly for the patient/guarantor and I, the undersigned, further agree and understand that I am directly responsible for all financial obligations to **BEYOND THE CURVE PEDIATRICS** and their associates. If for any reason I fail to meet my financial obligations to **BEYOND THE CURVE PEDIATRICS** and their associates, to seek a collection agency or court action as a means of collection, I understand that I will be responsible for the balance due on my collections plus all fees related to the collection.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information") by **BEYOND THE CURVE PEDIATRICS** in order to carry out treatment, payment, or health care operations. I understand that I should review **BEYOND THE CURVE PEDIATRICS** Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and I have the right to review such Notice prior to signing this Consent Form.
BEYOND THE CURVE PEDIATRICS reserves for itself the right to change the term of its Notice of Privacy Practices for Protected Health information at any time. If **BEYOND THE CURVE PEDIATRICS** does change the terms of Notice of Practices for Protected Health Information, I may obtain a copy of the revised notice by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.
I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. **BEYOND THE CURVE PEDIATRICS** is not required to agree to such requested restriction(s); however, if **BEYOND THE CURVE PEDIATRICS** does agree to my requested restriction(s), such restriction(s) are then binding on **BEYOND THE CURVE PEDIATRICS.** **(Continued on next page)**

At all time, I retain the right to revoke this consent in writing, to **BEYOND THE CURVE PEDIATRICS** except to the extent that action has already been taken. **BEYOND THE CURVE PEDIATRICS** may refuse to

treat Patient if he/she (or authorized representative) does not sign this Consent Form (except to the extent **BEYOND THE CURVE PEDIATRICS** is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, **BEYOND THE CURVE PEDIATRICS** has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that **BEYOND THE CURVE PEDIATRICS** is required by law to treat individuals).

I fully understand and have read the **INSURANCE POLICY** and the **CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS** and agree to abide by these policies.

Signature of parent/legal representative **Date**

State relationship if other than parent **Signature of Witness** *

If submitting electronically, your typed full name above serves as signature.

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

Authorization to Treat Minor

I, _____hereby authorize the following person(s) to bring my child(ren) in for therapy treatment.

I also allow them to make any therapy decisions that are in the best interest of my child.

I understand that this person is required to bring a picture ID with them to the therapy appointment in order to keep on file.

I can be reached at _____ for any questions and/or concerns.

Person authorized to bring/pick up my child to therapy appointments:

1) _____relationship _____

2) _____relationship _____

3) _____relationship _____

If submitting electronically, your typed full name below serves as signature.

_____ _____

Parent/Guardian (Printed) **Parent/Guardian (signature)**

This authorization will remain active, unless a written statement is received by the parent/guardian to revoke an authorized person.

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

OFFICE POLICIES & PROCEDURES

Effective January 1, 2018 the following policies have been implemented:

1. To better serve all our patients, if you miss 3 appointments without calling 24 hrs. prior to the appointment you may be released from therapy and placed on waiting list. This is not intended to cause any inconvenience to you, but to make these appointments available to patients who need ABA therapy.

2. If you will be late to your scheduled appointment, you must notify the office as soon as possible. If you do not notify the office, all therapy for that day may be cancelled.

THERAPY RECORDS RELEASE POLICY AND PROCEDURES

Effective as of January 01, 2018 our therapy records release policy has made the following changes:

1. A therapy records release must be filled out or requested on our patient portal by the parent or legal guardian of the patient **PRIOR** to the copying of any therapy records. Please request or fill out one release per patient.

2. All therapy records 12 pages or more will be copied for our personal use for a fee of $15.00 per patient. Therapy records less than 12 pages will be copied for your personal use one (1) time free of charge. All additional requests will have a $15.00 charge. Please allow 10 business days for this to be completed.

3. If you are transferring to another therapy provider you may complete a therapy records request for your child's records to be forwarded to your new provider at no charge to you. Please allow 30 business days for this transfer to be completed.

I have read and understand the **OFFICE POLICIES & PROCEDURES** and **THERAPY RECORDS RELEASE POLICY AND PROCEDURES.**

If submitting electronically, your typed full name below serves as signature.

_____ _____

Signature of parent/legal representative **Date**

_____ _____

State relationship if other than parent **Signature of Witness** *

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ **DOB:**_____/_____/_____

Treatment Dates/Information to be Released: _____

Specific Information is needed for:_____

Release To: ☐ **Release From:** ☐

Please state how you would like information released:

☐ Mail (provide address above) ☐ Fax Number (provide number above) ☐ Pickup

I DO ☐ **DO NOT** ☐ authorize the release of portions of the record relating to substance abuse, psychological/psychiatric conditions and/or communicable disease, including AIDS, if present.

I understand that this consent is revocable except to the extent that action has already been taken. This consent wil automatically expire 90 days from the date of signature, unless another date is specified below. (*)
Note: Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent.

If submitting electronically, your typed full name below serves as signature.

_____ _____
Signature of parent /legal representative Date:

_____
State relationship if other than parent

_____ _____
Signature of Witness * Date:

***Authorization not valid beyond** _____
Date cannot exceed one year from Date of Signature

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

Consent for Client Services and Assessment

I understand that the Beyond the Curve Pediatrics incorporates up to date evidence-based learning and behavioral training procedures in their programs,

I understand and acknowledge that the Beyond the Curve Pediatrics emphasizes the fact that children are treated individually and do not respond in the same way to training programs.

I understand that the Beyond the Curve Pediatrics does not make any predicative claims about the outcome of my child's program and success of levels of advancement.

I understand that the training procedures used by the Beyond the Curve Pediatrics may be delivered by various individuals that have been trained to carry out my child's specific behavior plan.

I understand that all staff members are supervised by a Board Certified Behavior Analyst who may not be on site during sessions.

I understand that I have the right to be informed of all training procedures used with my child

I understand that I have the right to remove my child from the training program at any time.

I understand that the Beyond the Curve Pediatrics may recommend termination of participation in the program if at any time clinical opinion deems it not to be beneficial.

I understand that any information concerning my child's involvement and intervention will not be released or shared unless the Beyond the Curve Pediatrics is ordered to do so by the courts, deems in necessary for an individual's safety, or is given my expressed written consent.

I understand that all original documents generated for my child's intervention are the sole property of the Beyond the Curve Pediatrics.

I authorize payment of medical benefits to the undersigning physician or supplier for services provided.

I authorize the release of any medical or other information necessary to process a claim. I also give my authorization to request payment of government benefits for the party who accepts assignment.
I understand and approve that the Beyond the Curve Pediatrics may use the following assessments: Direct Observation, Review of Records, Notes, Conversations, Photographs, Assessment Reports, Interviews, Data, Videos, Intervention/Treatment/Educational Plans, ABLLS-R, and/or VB-MAPP.

I give my consent for my child to participate in a behavioral intervention at the Beyond The Curve Pediatrics. This consent is valid until withdrawn or amended. Consent may be withdrawn at any time for any reason by submitting a request in writing to a representative of the Beyond The Curve Pediatrics.
If submitting electronically, your typed full name below serves as signature.

Name: _____ Date: _____

Witness: _____ * Date: _____

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

Declaration of Professionalism of Behavior Analysts for Prospective Client/Client's Family

PURPOSE: This document is designed to inform you about my background and ensure that you understand our professional relationship.

BACKGROUND: I received my B.S. from McNeese State University in Lake Charles, LA in Behavioral Science. I obtained my M.A. in July of 2017 from Ball State University in Applied Behavior Analysis. I received my certification (Board Certified Behavior Analyst) in September of 2017 and my License to practice Applied Behavior Analysis in Louisiana in November of 2017. I have been performing behavior analytic services in the Autism Spectrum Disorder field since February of 2013.

WHAT I DO: Behavior analysis is a unique method of treatment based on the fundamental assumption that the most important human behavior is learned over time and that it is currently maintained by consequences in the environment. My job as a behavior analyst is to work with specified behaviors you would like to change. With your input, I can help you discover what may be motivating certain behaviors, what behaviors would be more suitable in the situation, and then create and plan to teach these new behaviors. I can also develop a plan to help someone acquire a new behavior or improve skill level. I may request that family members of clients become active in treatment plans.

HOW I WORK: As a behavior analyst I do not make judgments about behavior. I try to understand behavior as an adaptive response (a way of coping with a situation). I then suggest ways of adjusting and modifying behaviors to reduce pain and suffering and increase personal happiness and effectiveness.

You will be consulted at each step in the process. I will ask you about your goals, I will explain my assessment and the results of my assessment in plain English. I will describe my plan for intervention or treatment and ask for your approval of that plan. If at any point you want to terminate our professional relationship, I will cooperate fully.

Please know that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results. If I believe that my consultation has become non-productive, I will discuss terminating it and/or providing referral information as needed.

CLIENT RESPONSIBILITIES:

I can only work with clients who fully inform me of any and all of their concerns. I will need your full cooperation as I try to understand the various behaviors that are problematic for you. I will be asking a lot of questions and making a few suggestions; therefore, I will need your total honesty at all times. I will be showing you data as a part of my ongoing evaluation of treatment and expect that you will attend to the data and give me your true appraisal of conditions. (Continued on next page)

One of the most unique aspects of behavior analysis as a form of treatment is that decisions are made based on objective data that are collected on a regular basis. At first, it may take several weeks for me to complete assessments and take the necessary data to determine the nature and extent of the behaviors that we are dealing with. However, once this has been completed, I will create an intervention or treatment plan and continue to take data to determine if it is effective. I will gladly share this data with you upon request and will be making treatment decisions based on this data.

Under my code of ethical conduct, I am not allowed to work with you in any other capacity except as your behavior therapist or consultant. It is not appropriate to ask myself or instructors under my supervision to babysit, transport, or perform any other non-therapy-based tasks.

I expect that you read the client handbook and adhere to all of the regulations of services that the center has created. This includes arriving to sessions in a timely manner, informing of medications or health conditions, confidential agreements, and/or cancellation policies.

CODE OF CONDUCT: I assure you that my services will be rendered in a professional and ethical manner consistent with accepted ethical standards. I am required to adhere to the *Guidelines for Responsible Conduct of the Behavior Analyst Certification Board*. A copy of these Guidelines is available upon request.

Although our relationship involves very personal interactions and discussions, I need you to realize that we have a professional relationship rather than a social one. According to my professional code of ethics, it is not appropriate for me to accept gifts or meals and it is not appropriate for me to be involved with your personal activities such as birthday parties or family outings.

If at any time and for any reason you are dissatisfied with our professional relationship, please let me know. I will make every effort to resolve any issues. For more information about my professional code of conduct, please visit www.bacb.com.

CONFIDENTIALITY: Clients and their therapist have a confidential and privileged relationship. I do not disclose anything that is observed, discussed or related to clients. In addition, I limit the information that is recorded in your file to protect your privacy. I need you to be aware that the confidentiality has limitations as stipulated by law including the following:

- I have your written consent to release information.
- I determine that the client is a danger to themselves or others.
- I have reasonable grounds to suspect abuse or neglect of a child, disabled adult, or an elder adult.
- I am ordered by a judge to disclose information.

WHEN WORKING WITH PARENTS/GUARDIANS: I enjoy and encourage parents/guardians of special needs children to be as active in their child's life, and treatment, as possible. I am here to help you and your child and am willing to discuss with you any special requests or needs. Please let me know if you or another approved individual (Continued on next page)

would like to view or participate in sessions. If you have any questions, concerns, or wish to review your child's progress, please feel free to set up an appointment with me.

_____ _____

Joshua Pommier, B.C.B.A.,L.B.A. Date

If submitting electronically, your typed full name below serves as signature.

_____ _____

Client Name Client Signature

Notice of Privacy Policy

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

PLEASE READ CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or verbally, are kept properly confidential. This Act gives you, the client, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse Protected Health Information (PHI).

Uses and Disclosures of Protected Health Information: Your Protected Health Information may be used and disclosed by your BCBA, your therapist, and/or our office staff for the purpose of providing quality health care services to you, to pay your health care bills, to support operation of the therapy practice and any other use required by law.

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent: Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law.

Authorization: I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans,

admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, (Continued on next page)
questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

All records from consultations and/or evaluations, test scores, and as progress notes.

All disability, Medicaid or Medicare records including claim forms, if applicable.

All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the entire period from consultation, start of treatment to last therapy session.

This protected health information is disclosed for <u>insurance coverage verification</u> <u>and medical billing purposes</u>.

By signing below, you acknowledge that you have read the attached Privacy Policy and understand that you are to maintain confidentiality of all past, present, and future clients, families, and staff at all times. Further, you consent to the release of your protected health information as outlined in the above policy.
If submitting electronically, your typed full name below serves as signature.

Client's Name _____

_____ _____

Signature of Client or Parent/Guardian Date

_____ _____

Witness * Date

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

Request for the Release of Client Information

I authorize Beyond The Curve Pediatrics to the release medical records as stated above to the following representatives of defendants/insurance carriers in the above-entitled matter who have agreed to pay reasonable charges made by you:

_____
Name of Representative or Company

_____
Representative Capacity (e.g. attorney, insurance company, school, etc.)

_____
Street Address

_____
City, State and Zip Code

_____
Items to be released

I understand the following: See CFR §164.508(c)(2) (i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties for billing purposes or court cases if needed.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect from date signed and until treatment ends at Beyond The Curve or at time you may choose to revoke this authorization.

If submitting electronically, your typed full name below serves as signature.

_____ _____
Signature Date

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

Private Consents

☐ **Picture and Video Release Form 1:** I give permission to the staff and agents of Beyond The Curve Pediatrics to video tape and/or take pictures of me/my child for training purposes and to share with me. I also understand that these pictures/videos will be immediately deleted once they have been viewed by parent/guardian

☐ **Holiday Celebrations:** I understand and acknowledge that Beyond The Curve Pediatrics may include celebratory activities surrounding traditional U.S. Holidays including New Years, Valentine's Day, Mardi Gras, St. Patrick's Day, Easter, Independence Day, Memorial Day, Halloween, Thanksgiving, and Christmas, and birthdays. Beyond The Curve Pediatrics wishes to be accepting and non-discriminatory to every unique client. We will make reasonable effort to make accommodations to ensure that you/your child receives socially appropriate treatment. If you would like to have any of these holidays excluded, please list them:
_____. If you would like to include any non-traditional holidays, please list them:
_____.

☐ **Toileting:** I understand that Beyond The Curve Pediatrics employs both male and female therapist who may be performing toileting routines as needed. I consent that staff members can escort my child to the restroom and aid in the full process of toileting as needed. If you would like to list any exclusions, you may do so:
_____. I also understand that by making exclusions, it may be difficult for Beyond The Curve Pediatrics to assist in toilet training due to staff constraints and availability.

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

Patient Bill of Rights

Beyond The Curve Pediatrics recognizes and respects the rights of patients and their families and treats them with courtesy and dignity. Our facility provides care that preserves cultural, psychosocial, spiritual, and personal values, beliefs, and preferences. We encourage families to become active partners in care by asking questions, seeking resources, and advocating for the services and support they need.

You Have the Right to...

Receive care that is free from discrimination. This means that you should not be treated differently because of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression.

Get important information about your care.

- In your preferred language.
- In a way that meets your individual needs related to vision, speech, hearing, or cognition.
- About your diagnosis, treatment plan, possible benefits, risks and side effects, likelihood of reaching your goals, options, and expected/ unexpected outcomes.
- Make decisions about care. This is called informed consent.
- At times, we are required, by law and regulation, to disclose or report certain information without your consent.
- Informed consent also applies to taking pictures, videos, or other images, and recordings of you for purposes other than your care.

Should you occur a problem

Beyond the Curve Pediatrics is committed to resolving all disputes at the local level. You may address all complaints to Joshua Pommier through email at beyondthecurvepediatrics@gmail.com, phone 337-435-0111, or mail 602 McAurther Dr, Ville Platte, La 70586.
If you are unable to resolve your dispute at the local level, you may contact the Department of Health and Hospitals at phone: 1-800-660-0488, Mailing Address: Louisiana Department of Health P.O. Box 629 Baton Rouge, LA 70821-0629.

Please keep this page for your records

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

The First Day of Therapy

We are very excited that you have chosen Beyond the Curve Pediatrics for your child's therapy needs. We want to make his/her transition into therapy as smooth and safe as possible. To help us achieve this goal there are a few policies that parents should be aware of:

- You must sign your child in and out of therapy every day.
- We do not allow food or drink in the lobby area. If your child has breakfast, please notify his/her therapist.
- No peanut or peanut products are allowed in the facility, due to allergies.
- Because of the nature of therapy, and to help your child remain safe, they must wear closed toed shoes.
- If your child receives medication during the day, the medication itself has to be signed in and out at the front desk. The BCBA must review and approve any request for staff to administer medication.
- Late to therapy or absences without prior notice are a burden to your child's therapy. Please be aware of the policy on repeated occurrences that is attached to this page.

What to bring for therapy

- 2 changes of clothing. If you do not provide clothing and your child needs them, you will be called for pick up.
- Pullups, Diapers, Wipes (If applicable)
- Lunch/ Snacks Please providing plates, bowls, sippy cups, and utensils is unnecessary as we have these available for client use.
- Bookbag (If applicable)

Do not bring to therapy

- Toys from home. We have an extensive number of items for your child to engage with. Items from home create confusion and are sometimes lost.
- Comfort items such as blankies, pacifiers, and stuffed animals. Again, these items become lost and are not appropriate in a therapy setting.
- DO NOT send medication in your child's book bag. This creates a dangerous situation for other clients and therapist.
- Please check your child's bags if you did not pack them.
- Weapons of any kind are prohibited.

Please keep this page for your records

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

Late or Absentee policy

Beyond the Curve Pediatrics has a sincere desire to provide the best and most effective care for your child. Repeated tardiness or absences to scheduled appointments are unacceptable. Emergency situations are exceptions to the policy. If your child has to be absence a doctor note or one-week prior notice is required. If your child must be late or absent, please give notice as soon as it is known. The answering machine is checked regularly during non-business hours. You may also email at beyondthecurvepediatrics@gmail.com. If you cannot keep the hours that you have previously agreed to or need to adjust scheduled times, please let us know so we can examine the schedule together and come to a resolution. Together we can help your child receive the best therapy possible. Below are the consequences for repeated No/call- No/Show events. Be advised these polices are strictly enforced.

Absence: Guardian does not contact.	Action	Late: Guardian does not contact.	Action
1st event	Reminder of policy	1st event	Reminder of policy
2nd event	Verbal reminder from BCBA	2nd event	Verbal reminder from BCBA
3rd event	Written Reminder and meeting with BCBA	3rd event	Written Reminder and meeting with BCBA.
4th event	Loss of spot/Placed back on waiting list	4th event	Loss of spot/Placed back on waiting
*********All instances absences or late arrivals are documented. ******* ** We understand that sometimes things can not be predicted, we only ask that when something arises, you notify our office ASAP so we can make the appropriate adjustments**			

Please keep this page for your records

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

I, (Initials) _____ have received and agree to the terms stated in the Late or Absentee Policy and The First Day of Therapy Policies. I understand that by failing to adhere to these polices may result in discharge and loss of therapy services for my child. If submitting electronically, your typed full name below serves as signature.

Printed name: _____

Signature: _____

Witness printed: _____*

Witness signature: _____*

Beyond The Curve Pediatrics, LLC

Fax: 1-337-468-3440
Website: https://beyondthecurveaba.com/

Client Handbook

Please return the last page of this Handbook with your completed packet

Statement of Assurance

We will work to the best of our abilities to help the client progress, but due to the nature of developmental delays, no guarantee or assurance of "cure" or "recovery" for any client can be made. Treatment outcomes may vary per client. Research shows that Applied Behavior Analysis (ABA) therapy is most effective therapy for most individuals with autism and related disorders and other developmental delays. Please note that improvements from one individual to another may vary. We will strive to do our best to bring out the best in you/your child.

Therapy Admission

A **consultation** and **assessment** must be conducted for all new clients, prior to services, and can be arranged by contacting our office for an appointment. All clients/parents/guardians must complete all required forms **before** services begin.

Waiting Area

The lobby/waiting area provides a place for clients, parents/guardians and visitors to wait until their scheduled appointment time. All clients should remain in the waiting area until a staff member calls the client back for the appointment. We have a strict confidentiality policy and are required to abide by HIPAA compliance for client privacy. This will limit that amount of access that our clients have to therapy areas. Compliance with all staff request is appreciated.

Attendance

Attendance for scheduled sessions is expected due to the nature of our business for staffing and scheduling of clients, along with disrupting the progress of your/your child's therapy. Students will be given their full time and treatment as scheduled. If you will not be attending for reasons such as illness, emergency, or ANY other reasons, you MUST contact the office and leave a message with office staff or on the answering machine. Please leave a message stating the client's name, date of services, and reason for absence. If the office is not notified prior to the appointment, $60.00 fee for each day may be charged for missed appointment(s) (Insurance Clients: it will be added to your bill but NOT billed to your insurance company). We reserve the right to charge for missed appointments if no attempt to notify the center of your absence, in order to keep our business running.

Arrival and Dismissal

We ask that all clients arrive prior to the designated appointment time and wait for the therapist or office staff to receive the client and escort them to the therapy room so that therapy sessions can begin on time. For HIPAA reasons, parents/guardians are not permitted to enter the therapy area or business office without notifying the receptionist or office staff. In addition to remaining in the waiting area, parents/guardians must sign the client in upon arrival and sign them out when the session is finished. We ask that goodbyes be made quickly in order to avoid behavioral issues.

Discontinuation of Services

If parents/guardians need to discontinue services for any reason, you must contact our office. Clients/Parents/Guardians will be responsible for any unpaid balances due. Should a client miss more than five (4) sessions without notifying our office, we have the right to place another client in the time slot allocated for you/your child. In order to keep our business going, steady flow of clients is a must. Remember, it is important to keep communication with our office staff for any time away from the center.

Medication

We will allow parents/guardians to administer medication to students (as prescribed by physician or an OTC that is needed for the client to make it through the session), and **only if necessary**. However, it is strongly recommended medicines be administered before and after therapy hours to prevent interruptions in instruction and programming.

We ask that parents/guardians informed our staff immediately of ANY changes in medication, new therapies, or discontinued medications.This may be very important for you/your child's program.

Program Fees and Cost

Cost of services for non-insurance clients, and all co-pays and/or co-insurance fees for insurance clients are to be paid daily. Should you need to make weekly or bi-monthly payments, you MUST meet our staff and have them prepare a written agreement stating so.

OCDD clients are expected to pay as soon as you are reimbursed by OCDD, usually within 30 days. OCDD and clients will receive a monthly statement for services at the beginning of each month for the prior month.

Private pay clients will be billed on a semi-monthly basis. Should your account become over 30-45 days past due, we reserve the right to put your/your child's sessions on hold until payment is collected.

Insurance based clients are responsible for checking all your deductibles, co-payment, and co-insurance payments due PRIOR to services. As a courtesy, we will verify benefits with your insurance company prior to services, but note that it is NOT a guarantee of payment by your insurance company. Ultimately, the client is responsible if the insurance does not pay. We will do our best to work with your insurance company for reimbursement and will allow up to 60 days for reimbursement. After 60 days, client will be responsible for dates of service, over 60 days, which insurance has not paid.

Should your insurance reimburse us afterwards, a credit will then be applied to your account or we will reimburse you. It is in your best interest to follow up on any unpaid claims. After 60 days, client may choose to discontinue services until insurance begins paying OR the financial responsibility will fall on the client until insurance begins to pay. we will do our best to work with you and your insurance company for reimbursement.

Emergency Center Closings

Emergencies do occur, and in extreme cases, the center is required to close early. During the school year, we advise parents/guardians to listen to the radio and television stations for information about school closings in Evangeline Parish. Generally, but not always, we will follow Evangeline Parish school closures. Please contact our office if such closures arise. We will contact all parents/guardians of closures as soon as a decision for closure is made by management. We must have an emergency number (included on enrollment forms) to contact the person responsible for picking the student in case of a weather emergency. Client accounts will not be charged for missed appointments due to emergencies that require the center to close.

Lice

Any clients exposed to lice must stay away from the center until all lice is removed and cleared from the head. State laws require students with lice be excluded from the center until the client has been treated and all nits removed from the head. Under no circumstances can a student, who has been sent home with lice, be allowed to return to the center the next day. Should you suspect your child was exposed to lice while at the center, Beyond The Curve Pediatrics shall not be held liable.

Illness

If a client becomes seriously ill or is seriously injured, emergency treatment will be sought at the nearest available hospital. It is imperative for each parent to leave at least two emergency telephone numbers on the admission forms where he/she can be reached in case an emergency should arise. Cell numbers are recommended as emergency numbers.

Parents will be contacted to pick up students who become ill during treatment sessions. In an attempt to prevent exposure to others, students **must** be picked up as soon as possible. Any student running a temperature more than 100.00, two or more bouts of diarrhea within one hour, or exhibiting any serious symptoms of any illness or injury will need to be picked up immediately and should be symptom free for 24 hours before returning. Students with fever, diagnosed with any illness or virus, suspected or diagnosed with pink eye, strep throat, flu, stomach virus, etc., should remain at home and be symptom free for 24 hours before returning to our center. Parents must inform us of the absence to avoid a charge to your account for the missed appointment.

Should a client miss sessions due to illness or for any reason, sessions may be rescheduled should our schedule allow. Should a client miss a session without notifying the staff, makeup session(s) will not be available. Should you suspect your child was exposed to a communicable illness or pink eye while at the center, Beyond The Curve Pediatrics shall not be held liable.

Accidents and Injury

Beyond The Curve Pediatrics and/or any of our staff are not liable for any injuries or illnesses individuals receive at our center by either the staff or another individual. Individuals with developmental disorders, behavior and language disorders display certain behaviors that can lead to injury of self or others. Our staff is trained to work with these types of behaviors, but accidents can and do happen even when due care and diligence is exercised.

Legal Custody or Other Court Orders

It is the responsibility of the parent/guardian to inform us if there is a legal custody or court order (such as a restraining order) regarding other parent/guardian. Furthermore, the parent/guardian must provide a list of people authorized to pick up the student from the center, as included in our admission packet. (It is parent/guardian's responsibility to notify our staff of any changes while student is attending).

Child Abuse Policy

Louisiana Revised Statute 14:403 requires anyone who works with children to report any suspected cases of neglect or abuse, physical or mental. This extends to all employees of Beyond The Curve Pediatrics

Damage to Property

Clients/Parents/Guardians will be held responsible for any damage to Beyond The Curve Pediatrics property caused by them/their child. Clients/Parents/Guardians will be responsible for reimbursement and repairs at reasonable cost, if deemed necessary.

Harassment, Intimidation, and Bullying Policy

Beyond The Curve Pediatrics will not tolerate any harassment, intimidation, or bullying of any kind by/to client, staff, parent/guardian, or visitor on the property. Management will investigate any reported incident of harassment, intimidation, or bullying. Should the investigation determine an incident has occurred; the individual involved shall be disciplined in accordance with this policy which may include discontinuance of the program, in serious cases.

Conferences and Parent Involvement

Communication with parents is extremely important, and we want to be certain to keep these lines of communication open. Please note that our staff cannot stop to consult with you about your child during session times. A conference can be scheduled in advance by contacting our office. Please schedule an appointment if you feel necessary.

Bags

A book bag or some type of bag should be brought with client to the center EACH session to keep communication notebooks, diapers/pull-ups (if need), change of clothes, medications (if needed, such as inhaler), reinforcer or snacks, ETC. Parents/guardians are asked to put the client's initials on all items in the book bag, as well as the book bag itself.

Concerns/Complaints

Any concerns/complaints about the services, staff, or property of our center should be addressed and discussed with a member of our management team. We welcome all input on our facility and operations. We will make every reasonable effort to correct, improve, or terminate any practice or policy that proves to be disruptive, harmful, or unsatisfactory to our center and/or clients.

Holiday Closures

Beyond The Curve Pediatrics will be closed on the following holidays: New Year's Day, Mardi Gras, Good Friday, Easter, Memorial Day, Labor Day, Thanksgiving, Black Friday, Christmas Eve, and Christmas.

Prior to each holiday, the center will post reminders in our lobby. Makeup sessions may be made up ONLY if our scheduling allows. Makeup appointments need to be scheduled in advance, at least one week prior to appointment day wanting to schedule the session.

Client Handbook Signature Page

I (print name) _____, the client or parent/guardian of

_____, have read and I fully understand the information in this

handbook and will follow the guidelines set forth by Beyond The Curve Pediatrics.

If submitting electronically, your typed full name below serves as signature.

_____ _____
Client/Parent/Guardian Signature Date

Date Received by Staff _____ *

Received by (Staff Member Name)_____

Please return this page with your completed intake packet