Parent Intake

Vision Statement

Campfire Behavioral Health (CBH) provides services to children and individuals aged 2-10 diagnosed with autism and other intellectual challenges. Services provided are ABA (applied behavior analysis). ABA sessions are provided via a two-tier model with a BCBA overseeing a case load and providing training to 1:1 therapists. ABA will be utilized as an intervention based upon it's demonstrated efficacy. Quality of service and individual care will always hold precedent over expansion or profits.

The founder of CBH is Veronica McNeal, BCBA, LBA. Veronica McNeal has over 20 years experience in the field of Applied Behavior Analysis. She holds a Master's degree in Education. Her supervision was completed under Dr. Jodi Cholewicki of the University of South Carolina. Veronica has held various supervisory and instructional positions. She founded and developed Behavior and Educational Supports in 2017. Prior to the development of this organization she worked as an instructor at the Carbone Clinic in Valley Cottage, New York. Veronica has received extensive training in B.F. Skinner's analysis of verbal behavior and applies this background in her work with the children and adults that she serves. As a parent of a child with autism spectrum disorder, Veronica brings a personal and understanding perspective to the services that she provides.

Diversity Statement

It is CBH's heartfelt intent to embrace all who seek their services or employment without discrimination or hesitation. CBH openly acknowledges that when we participate in an inclusive environment we all grow and benefit. CBH will never discriminate or make decisions based upon; gender identity or expression, sexual orientation, religion, ethnicity, age, neurodiversity, disability status, citizenship, or any other aspect that makes them unique.

Campfire Model

ABA is a standout method of treatment for children with autism spectrum disorder when provided in an effective manner. The earlier that services start the greater the prognosis. Campfire requires a commitment from families that enables us to ensure the effective implementation of services. Services are typically scheduled for Monday-Friday in a minimum of 2 hour blocks. An example schedule would be Monday-Friday from 8-10am. Campfire requires a minimum of a weekly 10 hour commitment.

If you are on the waitlist for services you will participate in the **parent training model**. With this model you will meet with a BCBA a minimum of 1 time monthly to review parent training goals and progress. In the event of cancelations or schedule openings, you will be contacted to schedule your child for a session. It should be noted that the full provision of services is optimal for your child. CBH encourages you to regularly check for new providers without waitlists and/or your current spot number on our waitlist.

Evidence-Based Practices

ABA has been demonstrated to be an effective treatment for children with ASD. Data are collected across programs and behaviors. Consultants refer to current and demonstrated technology when implementing procedures. CBH does not support and will not implement non-evidence-based

practices or methodologies. In keeping with current, ethical standards of patient treatment, CBH does strive to utilize a trauma-informed approach to treatment. Providers will work with you to determine the most effective and enjoyable approach for your child.

GETTING STARTED

The process for initiating services with vary based upon insurance coverage. For some insruances you will need an authorization for an initial assessment along with an ASD diagnosis. Other insurances allow us to start the treatment process with an ASD diagnosis alone. Please contact us at 253-349-6925 or info@campfireaba.com for more information.

CBH will contact you within 24 hours of receiving authorization or approval for services. During this initial contact, the assessment will be scheduled. Additionally, any paperwork and testing will be provided to you via email. **All paperwork and testing must be completed prior to the initial assessment**. You will also receive a potential schedule for attendance during the initial call. Retention of this schedule will be contingent upon the timely completion of the intake process.

Upon the completion of the initial assessment, the BCBA will write and submit the initial treatment plan for review and approval. In the instance of Tricare, an additional authorization will then be required for the onset of treatment. You will be contacted within 24 hours of CBH receiving the authorization for ABA treatment.

Once Services are Approved

Services will begin with a parent training. During this training the BCBA will complete a formal review of the treatment plan. Any needed materials will be provided for parent goals. A minimum of one parent training will be completed each month to review the progress and status of the parent training goals. After the initial 6-month treatment period, you will be eligible for parent trainings via zoom.

Continuing Services

A current authorization must be in place in order for your child to receive services. In the unfortunate event that the authorization lapses, services will need to be placed on hold until a new authorization has been approved. If services are placed on hold due to a lack of testing completion or signature provision, your child may lose their scheduled time.

WHAT TO EXPECT

When Services Begin

At the start of services we will spend time showing your child that they can trust us and have fun with us. During this time we will

Expectations for on-going BCBA supervision

BCBAs are required to supervise BTs and RBTs for 5% of your child's total scheduled hours. For example, if your child is receiving 40 weekly hours, you should expect to see the BCBA for a minimum of 2 hours a week. BCBAs work to oversee all of the cases on their caseload and are responsible for making

changes to programming. The BCBA will train BTs on programming and any changes. Additionally, the BCAB will work with and train parents while listening to any concerns they may have.

CLIENT RESPONSIBILITIES

All program participants are expected to miss no more than 10% of scheduled sessions. Twenty-four hours notice should be provided when canceling sessions and when at all possible. Services may be recommended for termination in the event of a no-call/no-show. In the event that a participant exceeds the 10% cancelation rate:

1. Notification will be provided that your child has exceeded the 10% cancelation rate for the month.
2. If your child exceeds the 10% cancelation rate for a second month, a meeting will be scheduled to discuss possible schedule changes, discharge or strategies to ensure improved attendance.
3. If your child exceeds the 10% cancelation rate for a third month, a determination may be made to discontinue services.

In the event of clinic sessions, arriving more than 15 minutes late without notification will be considered a no call/no show. Additionally, child pick up must occur within 5 minutes of session end time. In the event that a parent or guardian does not arrive in a timely manner for pick up, an out of pocket fee will be charged for child care.

Sick Policy

We want to keep children and employees healthy. Please keep your child home if they experience any of the following within 24 hours of a session:

- Fever
- Vomiting
- Excessive mucus that would be disruptive
- Excessive fatigue
- Diarrhea not caused by diet/diarrhea that does not stop even if from diet
- Contagious illness or rash

Client's should inform their BCBA of any and all concerns related to their treatment. Cooperation is required when treatment plans are developed and implemented to decrease problematic behaviors and/or increase appropriate behaviors. All staff members (BCBAs, RBTs, etc.) will expect to be treated with dignity and respect at all times. Behavior such as verbal threats, accusations, cursing, making defamatory, sexually or racially charged statements may result in the immediate discontinuation of services.

Campfire staff members are not allowed to work with your child in any other capacity except as your behavior therapist or consultant. A parent or caregiver should always be present when services are being provided

Company Policy on Dual and/or Exploitive Relationships

CBH explicitly forbids and advises against the development of relationships that may be dual or exploitative in nature. Given the sensitive aspects of our work, there may often arise opportunities that lend to employees and clients developing relationships and/or engaging in activities outside of those which are therapeutic. Some examples of dual relationships that may develop and should be avoided include:

- The exchange of personal information or advice
- Friending or communicating on social media sites
- Babysitting or providing services outside of therapy sessions
- Friendships or social activities outside of set treatment guidelines
- Giving or receiving gifts exceeding over $10.00
- Romantic or sexual relationships

In the event that a dual relationship occurs you should immediately notify your BCBA. Campfire leadership will assist in mitigating the impact of any dual relationships that have developed. The development of dual and/or exploitive relationships may serve as grounds for service termination.

CONFIDENTIALITY

Client's and their treatment team have a confidential and privileged relationship. Employees of CBH do not disclose any information that is observed, discussed or related to clients. Families must be aware that confidentiality has limitations as stipulated by law including the following:

- Written consent to release information
- There is a danger to the client or others
- Reasonable grounds to suspect abuse or neglect
- Order by the court

Parent Concerns

Please do not hesitate to contact us with any concerns regarding services or progress. You may contact CBH director Veronica McNeal directly at vmcneal@campfireaba.com.

By signing below I indicate that all company policies have been reviewed with me. Additionally, I understand all policies and have sought clarification as needed.

Parent Name and Signature	Date

Parent/Guardian Informed Consent for ABA Treatment

Beneficiary:

By signing below I indicate the following:

i. I understand that behavior modification procedures including but not limited to; direct instruction, modeling, shaping, reinforcement, and response cost will be used to decrease problematic behaviors and increase desirable behaviors. Further, I understand that I may request additional explanation of procedures at any time.

ii. I understand that my support, application and adherence with the treatment plan is essential to the progress of my child.

iii. I was informed about alternative strategies to this plan (if requested) as well as their advantages and disadvantages.

iv. I am aware that while ABA is a highly effective treatment methodology, there is no guarantee that my child will make progress and/or that my child will make progress with any specified time frame.

v. I understand that I may withdraw my consent for this plan at any time without repercussions.

vi. I understand that my child is the primary client in regard to the provision of services.

vii. I **AGREE** with the above statements and give my consent for the treatment plan.

Parent/Guardian 1:	Date:
Parent/Guardian 2:	Date:
Consumer (if applicable):	Date:

Authorization to Bill Insurance

Beneficiary Name: _____ **Date:**_____

I, the undersigned, hereby certify and attest that I have sought assessment, treatment and consultation from staff members at CBH for my child. I therefore authorize the treatment staff and personnel to release my or my minor child's medical information to the insurance company provided above for the purpose of determining and receiving benefits for medical bills.

I understand and acknowledge that CBH staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co=payments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address that I have provided. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

Parent/Guardian:	Date:

Video/Photo Release

Beneficiary:

Place Parent/Guardian Initials where applicable:	
	Video recording of my child may take place for internal training purposes.
	Videos and photos of my child **taken from the side/back and not revealing their face** are permitted for promotional purposes/use on the website.
	Videos and photos of my child taken are permitted for promotional purposes/use on the website.
	Videos and photos pf my child **ARE NOT** permitted for promotional purposes/use on the website.

By signing below I, _____ indicate that I have read and understand the policy outlined above.

Signature: _____ Date:_____

Campfire Behavioral Health

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The terms of this Notice of Privacy Practices ("Notice") apply to CBH, its affiliates and its employees. CBH will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by [Practice Name]. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent:

Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following: Any purpose required by law; If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence; To a government oversight agency conducting audits, investigations, civil or criminal proceedings; Court or administrative ordered subpoena or discovery request; To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law; To coroners and/or funeral directors consistent with law; If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and • To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION: Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public. Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION: Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic

format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid [Practice Name] in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself. Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint. Office for Civil Rights Department of HHS Jacob Javits Federal Building 26 Federal Plaza - Suite 3312 New York, NY 10278 Voice Phone (212) 264-3313 FAX (212) 264-3039 TDD (212) 264-2355 For Further Information: If

you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the CBH