ABA Services Intake Form

Person Completing this Form

Name: _____ ☐Parent ☐Guardian ☐Other: _____

Phone: _____ Email: _____

Are you authorized to consent for this individual's healthcare? ☐Yes ☐No

Client Information (Background information)

First Name: _____ Last Name: _____

Gender: ☐ Female ☐ Male ☐ Non-binary Birthdate: _____ SSN: _____

Address: _____

Please answer the following questions about the child's living situation:

A. Are the child's parents Divorced/Separated? ☐Yes ☐No
   a. If Divorced/Separated: ☐Joint ☐Sole
      Who is responsible for making medical decisions for the child?
   b. If sole custody, please specify which parent: _____
   c. With whom does the child reside? _____

B. Household #1: _____ % of time
   Name of Parent or Guardian #1: _____
   Name of Parent or Guardian #2: _____
   Names, ages, and relation to child of all other individuals in the home:
   _____
   _____

C. Household #2: _____ % of time
   Name of Parent or Guardian #1: _____
   Name of Parent or Guardian #2: _____
   Names, ages, and relation to child of all other individuals in the home:
   _____
   _____

D. Are both parents aware of services being sought at the Grand Valley Behavior? ☐Yes ☐No
   a. Does your child have a Guardian Ad Litem? ☐Yes ☐No
      If Yes, please provide their name: _____

E. Names and ages of any other siblings:
   _____
   _____

F. Primary Language: ☐English ☐Other: Specify _____
   Percent time child is exposed to non-English language(s): % of time_____

G. Has your child hit the following milestones? If so, please indicate the age they reached the milestones to the best of your ability.
- ☐ Sat up independently – Age _____
- ☐ Crawled – Age _____
- ☐ Walked – Age _____
- ☐ Ran – Age _____
- ☐ Ate solids – Age _____
- ☐ Spoke first word – Age _____
- ☐ Started saying 'mama,' 'dada' or any variation thereof – Age _____
- ☐ Began using short phrases – Age _____
- ☐ Began taking turns in conversation with you – Age _____
- ☐ Stated first name when asked – Age _____
- ☐ Began asking questions – Age _____
- ☐ Notice other children and shows desire to move toward them – Age _____
- ☐ Calms down within 10 minutes of a preferred adult leaving – Age _____
- ☐ Avoiding dangerous things after being warned by an adult – Age _____
- ☐ Assisting with dressing and undressing self – Age _____

Previous Evaluations/Assessments (Background information)

Please list any school testing and/or other evaluations of the client's skills.

Has the client ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other mental health counselor? ☐Yes ☐No ☐Unknown

If yes, please provide the following information:

A. Name:_____ Type of Specialist:_____ Date of evaluation: _____
Purpose of Evaluation / Services: _____

B. Name:_____ Type of Specialist: _____ Date of evaluation: _____
Purpose of Evaluation / Services: _____

C. Name:_____ Type of Specialist: _____ Date of evaluation: _____
Purpose of Evaluation / Services: _____

Educational History (Background information)

Please list the schools attended beginning with the most recent.

Is the client currently enrolled in daycare/school or Birth-3 Services? ☐Yes ☐ No
Daycare/School Name:_____ School District:_____
Program or Grade level: _____

Please list any other schools that the client has attended:

A. School Name: _____ School District: _____
Years of attendance: _____ Grade Levels: _____
B. School Name: _____ School District: _____
Years of attendance: _____ Grade Levels:

C. School Name: _____ School District: _____
Years of attendance: _____ Grade Levels: _____

Is the client receiving or has the client received special services or accommodations at school? ☐ Additional Notes:

☐Yes ☐No

If yes, please share what type and the general goals: (e.g. IEP, IFSP, 504 Plan):

Medical Information

A. Does your child have any medical or psychological diagnoses? ☐Yes ☐No
If so, please explain: _____

_____

Please list any medications your child is taking, the purpose of the medication, dosage and any concerns:

Medication:	Dosage:	Purpose for the med:
Medication:	Dosage:	Purpose for the med:
Medication:	Dosage:	Purpose for the med:

B. Does anyone smoke in the home? Yes ☐ No ☐
C. Family History: Do any of your child's family members have medical conditions or psychological diagnoses we should be aware of? Yes ☐ No ☐
D. Please indicate which conditions and/or diagnoses your immediate family (parents, siblings, spouse) and extended family (Grandparents, aunts, uncles, and cousins) have by checking the appropriate box(es) below:

Medical:

☐ Diabetes - If checked, please explain
☐ Pica - If checked, please explain
☐ Asthma - If checked, please explain
☐ Seasonal Allergies - If checked, please explain
☐ Food Allergies - If checked, please explain
☐ Allergies to medications/lotions or creams - If checked, please explain
☐ Other allergies - If checked, please explain
☐ Insomnia - If checked, please explain
☐ Difficulties with eating (vomiting, swallowing, etc.) - If checked, please explain
☐ Seizures or Epilepsy - If checked, please explain
☐ Genetic Disorder – If checked, please explain

Psychological:

☐ Attention Deficit and Hyperactivity Disorder (ADHD) - If checked, please explain
☐ Autism Spectrum Disorder: ☐ Level 1 ☐ Level 2 ☐ Level 3 - If checked, please explain
☐ Schizophrenia - If checked, please explain

☐ Anxiety Disorder: ☐ Generalized ☐ Social ☐ Separation - If checked, please explain
☐ Bipolar - If checked, please explain
☐ Obsessive Compulsive Disorder - If checked, please explain
☐ Depression - If checked, please explain
☐ Post Traumatic Stress Disorder - If checked, please explain
☐ Borderline Personality Disorder - If checked, please explain

Client's Interests

Please share information that will assist our team in working with your child.

A. Client preferences (favorite activities, food, interests/topics, sensory):

_____
_____
_____
_____

B. Client strengths:

_____
_____
_____
_____

C. Dislikes (aversions):

_____
_____
_____
_____

Concerns

A. Primary reasons for seeking ABA Services [Please explain]:

_____
_____
_____
_____

B. Additional concerns you would like support with [Please explain]:

Caregiver observations:

Below you will find multiple lists, including a list of challenging or maladaptive behaviors that children may engage in and skill lists, composed of behavioral cusps, pivotal skills, and other skills that will help our team build our understanding of your child.

[Please indicate whether your child engages in the activities or behaviors listed below by checking the boxes that you agree with].

Cognitive/Learning Skills:

☐ My child responds consistently when I call their name by vocalizing or looking at me.

☐ My child picks activities or toys to play with

☐ My child engages with a variety of different materials as opposed to focusing on only 1 to 3 activities or toys they enjoy.

☐ My child attends to activities or toys they choose for at least ☐ 30 s ☐ 1 min. ☐ 2 min. ☐ 5 min. ☐ 8 min. ☐ 10+ min

☐ My child attends to activities someone else picks for at least
☐ 30 s ☐ 1 min. ☐ 2 min. ☐ 5 min. ☐ 8 min. ☐ 10+ min

☐ My child works to solve simple problems using trial & error

☐ My child can do the following activities:

☐ matching ☐ comparing ☐ sorting ☐ organizing

☐ My child recognizes familiar places and people

☐ My child calls people by the correct name

☐ My child remembers previous events or activities

☐ My child imitates simple, single actions they see adults or peers do

☐ My child imitates multiple actions or step activities they see peers or adults do

☐ My child understands our basic household rules and boundaries

☐ My child resists doing things that are out of bounds or dangerous

☐ My child plays with toys in unusual ways, different than how I've seen other children play with toys

☐ My child plays by copying activities or games they've seen adults or peers engage in.

☐ My child notices and pays attention to what others around them are doing

☐ My child plays by pretending objects or toys are something they are not.

Adaptive or Life Skills

☐ My child feeds themselves

Uses a ☐ fork ☐ spoon ☐ hands only

☐ My child eats a variety of foods

☐ My child only eats specific foods

☐ My child independently drinks out of a cup

☐ My child dresses/undresses themselves

☐ My child chooses their own clothes

☐ My child brushes their teeth

☐ My child allows me to help brush their teeth

☐ My child brushes their hair

☐ My child allows me to brush their hair

☐ My child is in diapers

☐ My child is toilet trained

☐ My child physically explores their environment by

☐ Walking ☐ Running ☐ Climbing across/on a variety of surfaces

☐ My child seems aware of dangerous items or situations

☐ My child falls asleep at night without difficulty

☐ My child sleeps through the night

☐ My child takes baths or showers without challenging behavior

☐ My child washes independently or supports an adult in washing themselves by following simple directions, such as 'tilt your head back' or 'put your arms up.'

☐ My child can identify safe individuals to approach for help

Challenging behavior

❒ Meltdowns (intense emotional outbursts due to overwhelming stimuli or dysregulation)

❒ Shutting down (withdrawing and being non-responsive in potentially overwhelming situations)

❒ Self-Stimulatory behaviors (repetitive movements or sounds that occur at a level that they interfere with tasks or learning)

❒ Aggression (hitting, kicking, biting, pushing, pinching, etc.)

❒ Self-Injurious behaviors (biting or scratching self, hitting head or body parts with hands or other objects, etc.)

❒ Rigidity in thinking (difficulties with transitions, new routines, or unexpected changes).

❒ Sleep refusal or night waking

❒ Food selectivity and/or food refusal

❒ Eating or putting non-food objects in mouth

❒ Tantrums (intense emotional outbursts that include crying or screaming and at least 1 other challenging behavior to escape/avoid something or when denied access to something that is wanted)

❒ Property Destruction (throwing, tearing or breaking materials, etc.)

❒ Verbal threats or abuse toward others

❒ Threats of self-harm

❒ Fecal smearing

❒ Public masturbation

❒ Elopement

❒ Spitting

❒ Disrobing in public

❒ Lying or stealing

Communication and Language

Expressive language:

❒ My child uses words and sentences to get their needs met.

I can understand my child's words and phrases ❒
I can understand some of my child's words ❒
My child speaks too fast or slow ❒
My child uses an A/C device ❒

❒ My child uses non-verbal communication to get their needs met (check all that are used)

Pulling me to what is needed ❒
Using eye gaze or looking at what they want ❒
Gesturing or pointing ❒
Sign language ❒
Body movement (turning away or toward things) ❒

❒ My child can state their full name and age
❒ My child can state their caregiver's name and phone #

Receptive language:

❒ My child follows basic directions without support
❒ My child follows multiple step directions without support
❒ It seems like my child does not understand much of what I tell them.
❒ My child seems to understand most of what I tell them
❒ My child appears to hear when someone is speaking to them most of the time.
❒ My child will look at things I point out to them up to 20 feet away

Pragmatic communication:

❒ My child answers yes/no questions
❒ My child asks me questions
❒ My child shares their ideas with me
❒ My child waves or says hello/goodbye to others
❒ My child takes turns in conversation, sharing information and responding to questions or shared ideas.
❒ My child primarily talks about their own interests

Social and Emotional

- ☐ My child shows me things they are interested
- ☐ When my child shows me things, they look toward my face to see my reaction
- ☐ My child can label how they feel about something
- ☐ My child seems to recognize when others are sad, hurt, or angry
- ☐ My child frequently, multiple times a day, gets overexcited and has a hard time calming down
- ☐ My child seeks out others for social interactions (this is different than seeking out others for help with getting a basic need met)
- ☐ My child can self-soothe themself when they are unhappy
- ☐ My child accepts comfort from caregivers when they are hurt, sad or angry
- ☐ My child regulates their behavior by checking in with caregivers or others before doing something
- ☐ My child knows and communicates what they like and don't like with others
- ☐ My child plays with others
- ☐ My child can be both a leader and follower in play with others
- ☐ My child shows a preference for playing with others who are much older or much younger than they are
- ☐ My child only likes to play their way
- ☐ My child has limited interest in new toys, instead they play with the same materials/toys repeatedly
- ☐ My child becomes upset when others join their play
- ☐ My child moves away when others come near them or try to engage with them.

Executive Functioning (Organization/Flexibility/Attention)

- ☐ My child has a hard time starting or completing tasks
- ☐ My child struggles with organizing or planning for future events or activities
- ☐ My child appears to struggle to pay attention or listen
- ☐ My child appears to process information slower than others
- ☐ My child will focus intensely on their interest but struggles to focus on things they did not choose
- ☐ My child seems to 'zone out' or seems to daydream a lot
- ☐ My child seems to struggle with knowing where or how to start an activity, game, or task
- ☐ My child seems to struggle with following directions
- ☐ My child has a hard time managing their impulses
- ☐ My child has a hard time managing their emotions
- ☐ My child seems to struggle with their short-term memory (remembering names, earlier conversations, etc.)
- ☐ My child seems to struggle to learn from past mistakes
- ☐ My child seems to lose track of time
- ☐ My child stays with challenging tasks
- ☐ My child is open to a variety of ways of doing something
- ☐ My child can spend a long time playing or attending to activities or materials they enjoy (30+ minutes)

Description of Services

Applied Behavior Analysis (ABA) Intervention Services: Board Certified Behavior Analysts (BCBAs) provide evidence-based treatment using Applied Behavior Analysis (ABA) strategies to teach new skills, increase emerging skills, address challenging behavior, and support individuals with autism in a variety of settings.

☐ Early Intensive Behavioral Intervention (EIBI) also called Comprehensive Behavior Treatment: The BCBA works with families to develop, implement, and refine intensive and comprehensive ABA-based programs individualized based on each child's strengths and needs. Services are provided in-home, in clinic, in community settings, and via telehealth (when necessary) and are implemented by behavior technicians and supervised by the BCBA. Services typically range between 20 and 40 hours per week and last 2 to 3 years.

☐ Focused Behavioral Services: The BCBA works with families to develop, implement, and refine an ABA-based program, individualized for each child based on their areas of strength and need. Services are provided in-home, in clinic, in community settings, and via telehealth (when necessary) and are implemented by behavior technicians and supervised by the BCBA. Services typically range between 10 and 20 hours per week and last 2 to 3 years.

ABA Service Fading and Termination

1. Direct services is typically faded over a period of 24 to 36 months as skill acquisition progress is established, generalized, and maintained, and caregivers, along with other stakeholders, are able to consistently implement behavior change tactics.
2. Opportunities to decrease treatment hours will be evaluated biannually. Fading of services will occur based on successful skill acquisition and reduced or eliminated maladaptive or behavior challenges. Fading services may include:
    - Shortening sessions
    - Decreasing the frequency of RBT or BCBA sessions
    - Decreasing the frequency of BCBA consultations and caregiver training
    - Providing BCBA consultation only
    - BCBA will be available by appointment should the need arise.

Hours of Availability

Please mark the times you and the client ARE available for services.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
9:00					
10:00					
11:00					
12:00					
1:00					
2:00					
3:00					
4:00					
5:00					

Additional Comments

_____

_____

Cultural Considerations

Please describe below important cultural practices, rituals, traditions, or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship.

_____

_____

_____

_____

Evaluations/Assessment Reports

Please attach a copy of your child's reports (please include all that apply):

- ☐ Diagnostic Evaluation Report
- ☐ IEP/IFSP/504 Plan
- ☐ Functional Behavior Assessment (FBA) /Behavior Intervention Plan (BIP)
- ☐ Prescription for ABA
- ☐ Mental health directives
- ☐ Medical advance directives
- ☐ Powers of attorney
- ☐ Discharge summaries or evaluations from any inpatient/outpatient services within the last 5 years
- ☐ Least restrictive alternative orders
- ☐ Other: _____

Coordination of Care

Please list and provide contact info for all other providers for your child:

- ☐ Primary care provider: _____ Contact: _____
- ☐ School teacher: _____ Contact: _____
- ☐ Speech Language Pathologist: _____ Contact: _____
- ☐ Occupational Therapist: _____ Contact: _____
- ☐ Other: _____ Contact: _____
- ☐ Other: _____ Contact: _____
- ☐ Other: _____ Contact: _____

Insurance information:

Please attach a copy of your insurance card (front and back)

Primary Insurance Company: …… _____

Subscriber ID # (including letters): …….. _____

Group Number: _____

Secondary Insurance Company: …….. _____

Subscriber ID # (including letters) …… _____

Group Number: _____

Insurance Policyholder Full Name: …… _____

Insurance Policyholder Date of Birth: …… _____

Insurance Policyholder Address: ……. _____

Insurance Policyholder Relationship: Self, Spouse, Child, Other: _____

Patient Authorization

I authorize the release of any medical and insurance information necessary to process any claim.

Patient Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Patient Full Name: _____

ABA Service Agreement and Consent Form

This document contains important information about Grand Valley Behavior; Services and Consulting applied behavior analysis (ABA) professional services and practice policies. It is important that you read through this information carefully and ask questions for clarification at any time. When you sign this document, it will represent an agreement between you and GVBSC to provide ABA services. You, the consumer, reserve the right to withdraw at any time from these services. Again, feel free to contact GVBSC with any questions or concerns about GVBSC's ABA Services. GVBSC abides by the Behavior Analyst Certification Board's guidelines for responsible conduct.

Services Offered

GVBSC abides by the Behavior Analyst Certification Board Guidelines for Responsible Conduct

- Admission into ABA services will be available to children, adolescents, and adults with or without a diagnosis based on the need/desire to modify established behaviors. Certain provisions may apply in regard to diagnosis if someone is seeking funding for the service through a third party, such as private insurance or Medicaid.
- When needed, GVBSC will provide the client/family with contact information for other professionals who may be better able to assist with the client's needs if GVBSC cannot meet specific treatment needs.
- Services will focus on the development and implementation of a functional behavior assessment and an ABA treatment plan. ABA services will be provided by a Board-Certified Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst (BCaBA) or a highly trained Behavior Specialist under the supervision of a BCBA.
- GVBSC provides ABA services based on the client's current level of individualized needs. The treatment plan will structure antecedent and consequence-based strategies that are skill based, functionally equivalent, and non-aversive.
- Behavioral assessment results are available to the client and/or family, and a preliminary treatment plan meeting will be scheduled with the client and ABA professionals to review the proposed service type(s), treatment plan goals and objectives, recommended duration and length of treatment, and a discharge plan for the client.
- Upon discharge, recommendations will be provided to support continued progress or address persisting concerns.
- The contents of both the assessment and treatment plan will be explained to the client and/or family, and GVBSC staff will willingly answer any related questions about the assessment or proposed service. GVBSC understands that this information is confidential and will abide by established confidentiality policies and procedures.
- In addition to direct ABA treatment, ABA services also include training and ongoing consultation in the principles of applied behavior analysis as they pertain to the client's treatment plan with family, educators, and any related service providers.

Assessment, Preparation, and Participation

It is important for any individual to be able to perform at their best during an assessment. Please let the GVBSC ABA office know of any illness or changes in medication or diet that may necessitate an assessment to be re-scheduled. Grand Valley Behavior believes in non-aversive, trauma-informed care using an integrated treatment approach to create a positive learning experience for any individual. Thus, GVBSC also asks that our clients and/or families share information about an individual's preferences, dislikes, and needs that may arise during a clinical assessment. An initial assessment may be conducted to make recommendations, but the complete assessment process may take 15-20 total hours, or possibly longer, depending on the specific assessment procedures needed.

Upon completion of the assessments, clients and/or guardians will receive a review copy before submission to insurance. Services will not begin until insurance approval is received, or a self-pay agreement is in place. Once authorization is in place, GVBSC will assign staff, set a therapy schedule, and begin services. During ABA therapy, you may observe therapists using technology to collect data, write notes, provide instruction, and/or use as reinforcers. The content of therapy sessions will be individualized according to treatment needs. This may include structured table time, toy / game play, outside play, contrived and/or casual conversation activities, daily living skills instruction, etc. Therapy services will also include implementation of empirically validated behavior modification procedures. If at any time you have questions about the content/schedule of therapy, contact your assigned behavior analyst.

Staff changes may transpire throughout the duration of treatment for clients due to many reasons. However, any staff changes would only be considered and implemented with parent/caregiver collaboration and approval. Staff changes for both the supervising staff (BCBA, BCaBA) and direct care staff (RBT) may transpire from one/more of the following reasons:

- Clinical needs such as:
    - Generalizing skills
    - Increasing opportunities for social aspects
    - Providing new skill sets from fellow staff members
    - Ensuring treatment fidelity (e.g., multiple different staff are seeing the same skill deficits and/or provide consistent implementation of treatment programs)

- Personnel Changes o Client re-location to another region
    - Client changes in insurance coverage (this would dictate what would be covered by insurance)
    - Insurance changes to policies and procedures covering ABA services
    - Client needs (e.g., behavioral, skill deficits, age range, etc.)

Assessments are typically conducted bi-yearly. An updated treatment plan will be provided per authorization or update period.

Additionally, parent/caregiver participation is an expectation of service. Participation may include team meetings, data collection, and implementation and involvement in the implementation of recommended strategies. If there is lack of involvement, GVBSC reserves the right to reconsider the appropriateness of service.

Appointments

GVBSC's ABA staff is committed to providing consistent, reliable service as scheduled and agreed upon by the client/family. GVBSC proposes a preliminary set of hours for ABA services within the initial treatment plan, considering medical necessity (physician recommendation or prescription) and results of the behavioral assessment. A monthly or weekly schedule of service will be worked out between the client/family and Grand Valley Behavior staff assigned to the case. Regular attendance is key to seeing progress in your child's therapy session. Multiple cancellations and late arrivals are a hindrance to your child's progress and an inconvenience to the therapists. Please refer to our cancellation policy below:

- More than 2 sessions missed with less than 24 hr notice in a one-month period will result in a warning letter from GVBSC detailing our cancelation policy.
- Cancelations with less than 24hrs notice after receiving a warning letter will be charged a $50 cancelation fee
- Late arrivals, arriving >30 minutes late to a session, with less than 24 hour notification, will result in a canceled session; and/or, picking up you child >30 minutes before the end of their session with less than 24 hour notification will result in a cancellation.

- Sessions cancelled with at least 24 hrs. advanced notice will not be charged.
- Sessions cancelled with less than 24 hrs. due to contagious illness (fever, vomiting, diarrhea, pink eye, contagious rash, etc.) will not be charged.
- Scheduled family vacations/other scheduled periods of absence will not result in any charges; however, prior notice is required.
    - Consult with your BCBA to determine the course of action if you are taking a long break from services.
- Other emergency situations will not warrant any additional charges.

Families and therapists are encouraged to reschedule missed therapy sessions. In any situation where multiple sessions must be missed, re-evaluation of the client may be required to best determine the subsequent plan of action.

Sick Policy

Fevers are common in young children and are often a signal that something is wrong. Please do not bring your child to therapy if he/she has a fever of 101.0F or higher. Our policy is that your child must remain free of fever for 24 hours before returning to services. This means that if your child is picked up at 3:00 p.m., but still has a fever at 6:00 p.m. or later, he/she cannot return to the therapy the next day. The 24 hours begins when your child's fever has broken and remains in a normal range.

Diarrhea / Vomiting due to illness is highly contagious. If your child has these symptoms, please keep him/her home. If your child has 2 or more diarrhea episodes, or any uncontained diarrhea while at therapy, you will be called to pick him/her up. Our ABA Technicians use proper hand washing techniques between diaper changes but, please understand that germs from diarrhea can be spread through carpets, toys, swings and direct contact. It is very difficult to keep from spreading these germs to other children. If your child vomits while at therapy, you will be called immediately to pick him/her up. Please keep your child at home until 24 hours after the vomiting has stopped. When children return too soon, there is a much higher rate of recurrence and contagiousness.

Colds are a common occurrence. However, there are some symptoms that warrant keeping a child at home. These include, but are not limited to, bad cold with hacking or persistent cough, green or yellow nasal drainage, and productive cough with green or yellow phlegm being coughed up. These symptoms may be present with or without a fever. If your child just has a cold, please notify their ABA Technician. We encourage extra fluids and proper hand washing.

Communication

GVBSC is committed to responding to any questions or comments regarding ABA Services in a timely manner. The Behavior Specialists, Behavior Analysts, and ABA Program Managers are committed to providing the best quality service to clients, which includes timely, professional communication. The clients will be provided with the telephone numbers and email addresses of those individuals involved in direct treatment service and planning. However, basic information about Grand Valley Behavior's ABA Services is available through our website (www.grandvalleybehavior.com). More detailed inquiries (non-case related) and referrals for ABA service should be directed to the ABA Program offices.

Grand Valley Behavior does not offer on-call coverage for ABA services and programs on a 24-hour basis. Clients may contact their ABA Program office with questions or comments by telephone or email. Concerns may also be directed to Grand Valley Behavior's management.

Grand Valley Behavior Contacts:
Clinic Phone#: 970-317-7175
Jessica Mulvey, Owner: jmulvey@grandvalleybehavior.com
Nathan Phillips, Manager: nphillips@grandvalleybehavior.com

Discharge/Termination of Services

As the consumer, you reserve the right to ask for treatment team changes or withdraw from services at any time from these services. This agreement involves an understanding from you, the consumer, to follow through with treatment plan suggestions to maximize your child's treatment progress. Failure to adhere to the treatment recommendations may contribute to potential discharge and/or transition of services. Furthermore, if disagreement regarding behavior change procedures and/or treatment plan goals occur, you, the consumer, will work with the BCBA to alter said goals. Justification and clarification for behavior change procedures will be thoroughly explained so you the consumer will understand reasoning for implementation. Upon agreement of plan/goals, failure to adhere to the plan will result in termination of treatment. Discharge may also occur if GVBSC is unable to meet your scheduling/ treatment needs due to staff availability.

Other reasons for discharge/termination:

- Caregiver/client request
- Inadequate progress despite treatment fidelity over a substantial period of time (criteria will be discussed with BCBA prior to discharge)
- Complete outcome of service: Client's referred excesses and deficits have been addressed and remediated. All problem behaviors identified at entry of service have been addressed and are exhibited within typical ranges. This may also include age-appropriate ranges of development on standardized testing in the areas of diagnostic criteria, cognition, language (basic speech and language as well as a pragmatic language), social problem solving, executive functioning, and adaptive skill functioning.
- Insurance cancellation or changes affecting authorization approval
- Failure to pay bill according to agreement
- Behaviors/challenges are determined to be outside the scope of our expertise
- Scheduling conflicts resulting in inadequate staff availability
- Abusive and/or inappropriate behavior/language towards staff
- Failure to provide a safe, effective learning environment
    - Unsanitary conditions
    - Parent/spouse conflict
    - Substance abuse
    - Household pets not contained
    - Siblings/outside individuals interfering with session times

GVBSC and its employees are considered mandated reporters. If there is suspicion of abuse or neglect, we are required by law to report our concerns to the appropriate authorities. If the circumstance is such that it places our staff in an inappropriate, uncomfortable, or dangerous situation, services will be immediately terminated.

Insurance and payment

GVBSC is in network with several insurance companies. Upon approval for services, we will bill insurance directly for services rendered. This requires the release of PHI for billing purposes. By agreeing to services covered by insurance, you agree to the release of this information. The client is responsible for co-payments and or deductibles as assigned by the insurance. As part of our provider agreement and your contract with your insurer, GVBSC is legally required to collect copays. Copays can be collected at the time of services or billed at a later date. Failure to pay copays without an agreement in place may result in loss of services. If you have a concern about ability to pay, contact Nathan Phillips to discuss payment plan options. There are several grants available to assist with ABA copays. These include:

ACT Today and ACT Today for Military Families- http://www.act-today.org
Autism Cares- https://autismcaresfoundation.org
Ezra B Smith Foundation- http://www.ebsmithfoundation.org
The Autism Community in Action Now- https://tacanow.org/family-resources/autism-grants/
United Healthcare Children's Foundation- https://www.uhccf.org/apply
Refer to http://www.autismsupportnetwork.com/resources/autism-grants-unitedstates for a more complete list.

If there are insurance payment issues, we will attempt to resolve any disputes with the insurance company. The client will be responsible for any discrepancy that cannot be resolved with the insurance company (i.e., paying for sessions if we go over the allowed amount, insurance denial despite approved authorization etc.).

If your insurance policy changes, you are responsible for notifying the company as soon as possible to avoid any lapse in services. Failure to provide sufficient notice and documentation of policy changes may result in additional charges for services rendered and a suspension of services until new insurance approval is granted. If a suspension in services occurs, we will not be able to guarantee your child(s) therapy schedule will be reserved.

Co-Pay & Self Pay:

Your Co-Pay amount will be determined based upon your specific insurance policy. You will be notified of your specific responsibilities for rendered services. You have the right to alter the hours for RBT/Supervisor at any time upon discussion with your Supervisor. Any changes will warrant a new contract. Private Pay cost for services will be:

- $50 per hour for ABA services rendered by a Behavior Technician (RBT)
- $95 per hour for services rendered by a BCBA / Supervision service. An initial assessment will cost.
- $425 for an assessment.
- $23 per trip for transportation to and from the clinic.

Consent

Your signature below indicates you have received and read the information in this document. All parents/legal guardians' consent is required prior to implementing ABA services.

Client	Date
Parent/Guardian (if applicable)	Date

FINANCIAL AGREEMENT POLICY

Grand Valley Behavior believes that part of good health care practice is to establish and communicate an office and financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have a full understanding of our policies.

The Financial Agreement is intended to provide patients/legal guardians with an understanding of the financial aspect of healthcare services provided at Grand Valley Behavior. Patients/legal guardians should read this agreement carefully before deciding and proceeding with care.

1) INSURANCE: We are participating providers with most insurance plans. We will file all the claims for these plans. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance. To bill your insurance and to meet filing guidelines we do ask for a copy of your insurance card and a photo ID. If our providers are not listed in your plan's network, you may be responsible for partial or full payment.

2) POLICY ON NON-COVERED SERVICES: This office offers access to many innovative services and procedures, some of them are deemed as "not covered" by insurance. You will be responsible for payment in full at the time of service.

3) RESPONSIBILITY FOR PAYMENT: You understand that you are financially responsible to Grand Valley Behavior for charges not covered by the assignment of insurance benefits and all non-covered charges.

4) AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS: You authorize Grand Valley Behavior to furnish information to insurance carriers concerning treatments and hereby assign to Grand Valley Behavior all payments otherwise payable to me for Grand Valley Behavior services.

5) SELF PAY PATIENTS WHO ARE INSURED: Self-pay patients will be identified when they make the initial contact with the office and will be defined as a patient who has no health insurance coverage of any kind, including federal and state health care programs such as Medicare and Medicaid or other insurance coverage such as insurance provided by a school, or AFLAC

a) does not claim third party liability for the patient's health care treatment
b) has no other responsible party covering the expenses associated with the care received from our office Self-pay patients will be required to pay $425 for the Initial Assessment (up to 6 hours) prior to scheduling.

6) BILLING AND COLLECTION FEES: Grand Valley Behavior will submit a claim for payment to your insurance company. In the event your insurance carrier/company denies the services provided, you will be responsible for the payment in full. We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay an additional $50.00 fee to cover the fees imposed to Grand Valley Behavior by the collection agency to collect the outstanding balance.

7) PAYMENT: is expected at the time of invoice. Payment will include any unmet deductible, co-insurance, co-payment amount, charges not covered by your insurance company. Any additional charges incurred will be invoiced the first (1) week of each month. All charges are due on or before the fifteenth (15) of each month.

8) INVOICING: Notification will be sent to the mailing address on file. Notification will be sent the first (1) week of each month for the prior month. All charges are due on or before the fifteenth (15) of each month via check or through GVB's client portal.

I have read and understand the practice's financial policies and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice at any time.

Client / Responsible Party

Date

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

ACTIVITY CONSENT AND APPROVAL

INFORMED CONSENT, RELEASE AGREEMENT, AND AUTHORIZATION

Community-based ABA therapy at Grand Valley Behavior helps address problem areas and develops skills across various community settings such as libraries, grocery stores, and museums. These activities, which can be combined with or incorporated into our center-based therapy, ensure that the progress each child shows during therapy continues when they're out in the community.

Grand Valley Behavior's community programs focus on maintaining appropriate behavior across a variety of settings. Examples of our activities and the skills that are practiced include (but are not limited to):

Eureka! McConnell Science Museum	*social interactions, accepting "no", challenging behavior*
Museum of the west	*Adapting behavior to the environment, social interactions*
Dinosaur Journey	*Tolerating crowds, social interactions, accepting "no"*
Get Air Trampoline Park	*Social interactions, challenging behavior*
Libraries	*Waiting in line, adapting to the environment (staying quiet)*
Western Colorado Botanical Gardens	*Waiting in line, tolerating crowds, accepting "no"*
Fast Food Restaurants	*using a list, social interactions, accepting "no", communication*

I understand that participation in community activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators.

In case of an emergency involving my child, I understand that efforts will be made to contact me. In the event I cannot be reached, permission is hereby given to the medical provider to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose protected health information to the adult in charge and/ or any physician or health care provider involved in providing medical care to the participant. Protected Health Information includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

With appreciation of the dangers and risks associated with programs and activities including preparations for and transportation to and from the activity, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Grand Valley Behavior and all employees, related parties, or other organizations associated with any program or activity.

Name (print): _____ Relationship to participant: _____

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient/Client

Address

Phone Number | Birthdate

Name of Guardian or Legal Representative

Address

Phone Number | E-mail

Person/Organization to Release Information

Grand Valley Behavior; Services and Consulting

Street Address

397 Ridges Blvd.

City | State | Zip Code

Grand Junction | CO | 81507

Phone Number | Fax Number

970-317-7175 | 970-360-5542

The following persons/organizations are hereby authorized to receive my entire medical record, treatment record and diagnostic record:

Person/Organization to Receive Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

Person/Organization to Receive Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

Person/Organization to Receive Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic, and therapeutic care, tests, counseling, and medical prescriptions for the purpose of: (Check all that apply)

☐ Change of doctor
☐ Individual request
☐ Workers compensation
☐ Specialist referral
☐ Insurance purposes
☐ Continued treatment
☐ Legal investigation
☐ Other: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law. This authorization is valid for _____ (Check one) ☐ days ☐ months ☐ years following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information. By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization. I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

_____	_____	_____
Patient's Signature	Patient's Name (print)	Date
_____	_____	_____
Guardian or Legal Representative's Signature	Guardian or Legal Representative's Name (print)	Date

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

Consent for Communication

Patients/Clients frequently request that Grand Valley Behavior Services and Consulting (GVBSC) communicate with them by phone, voicemail, email, or text. GVBSC respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email, or text. GVBSC will not be responsible for any privacy or security breaches that may occur through voicemail, email, or text communications that you have consented to.

Risk of using email
I understand that GVBSC providers and staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may affect the privacy of my personal health care information when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- ☐ Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- ☐ Email may be sent to the wrong address by any sender or receiver.
- ☐ Email is easier to forge than handwritten or signed papers.
- ☐ Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- ☐ Email service providers have a right to archive and inspect emails sent through their systems.
- ☐ Email can be intercepted, altered, forwarded, or used without detection or authorization.
- ☐ Email can spread computer viruses.
- ☐ Email delivery is not guaranteed.

Conditions for the use of email
I agree that I must not use email for medical emergencies or to send time sensitive information to my/the client's Providers. I understand and agree that it is my responsibility to follow up with GVBSC, if I have not received a response to my email within a reasonable time.

I agree that the content of my email messages should state my question or concern briefly and clearly and include (1) the subject of the message in the subject line, and (2) clear identification including client's name, parent's name, and telephone number in the body of the message. I agree it is my responsibility to inform GVBSC of any changes to my email address. I agree that, if I want to withdraw my consent to use email communications about my/the client's healthcare, it is my responsibility to inform my/the client's Providers or staff member only by email or written communication.

Understanding the use of email
I give permission to GVBSC Providers and staff to send me email messages that include my/the client's personal health care information and understand that my email messages may be included in my/the

patient's medical record. I have read and understand the risks of using email as stated above and agree that email messages may include protected health information about me/the client, whenever necessary.

You may choose to limit the type of voicemail, email, or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐ I do not consent to any voicemail, email, or texting communication.
- ☐ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my child's protected health information only by the following means (check all that you consent to):
  - ☐ Email
  - ☐ Text
  - ☐ Voicemail

_____
E-mail address you are consenting to communicate through:

_____
Phone number you are consenting to communicate through:

_____ _____
Patient Signature: Date:

_____ _____
Printed Name: Relationship to Client

Introduction

GVBSC's Code of Conduct is a tool, set of rules and values, to reference as a guide to foster a respectful, supportive, and enriching environment for GVBSC clientele, employees, and stakeholders. Our code of conduct recognizes the crucial role all stakeholders play in ensuring a positive environment is maintained and optimal treatment is achieved. By adhering to the guidelines outlined below, we can collectively support the well-being, growth, and enjoyment of all clients.

General Guidelines

1. Respect and Inclusion
    - Treat all clients, caregivers, and GVBSC employees with respect and courtesy.
        1. We know that when life is stressful and challenging, it can be overwhelming, and it can be tempting to dwell on what is going poorly or is problematic. While GVBSC staff absolutely understand this, we recognize that, after the critical step of identifying these problems or concerns, we need to maintain a growth mindset and focus on solutions and learning.
    - Encourage inclusive behavior, promoting a culture of acceptance and understanding.
        1. This means GVBSC works to provide equal access to opportunities and resources for all clientele and stakeholders as guided by GVBSC policies and procedures and the BCBA and RBT ethics codes.
    - Refrain from any form of discrimination or exclusion based on race, gender, ability, or background.
        1. This means that, at GVBSC, we recognize and deeply respect that each client, family, employee, and stakeholder have their own distinct value system, traditions, experiences, backgrounds, hopes, and dreams. We pair employees with clients intentionally based off areas of strength and need. All parties involved in ABA are encouraged to identify potential biases, the effect they may have on ABA services, and individual strategies to prevent them from interfering with services and treatment progress.
2. Communication
    - Communicate openly and respectfully with other service providers, caregivers, and staff.
    - Address any concerns or issues promptly and constructively.
    - Follow appropriate channels for raising concerns or grievances.
        1. Collectively, the above statements mean taking turns being a listener and speaker in conversation, speaking with a conversational tone and volume in lieu of yelling, using polite speech and actions in communicative exchanges, avoiding coercive behavior in communication, following the chain of command when sharing concerns, and working to be solutions oriented. Yelling or threatening

employees, co-workers, or stakeholders is unacceptable behavior and may lead to termination of employment or services.

3. Supervision and Safety
    - Ensure timely arrival and is pick up for services.
        1. If you have challenges with transportation, please ask us for information about Non-Emergency Medical Transport (NEMT).
    - Inform staff of any allergies, medical conditions, or other special needs the client may have.
        1. GVBSC prioritizes client health and safety; and, having access to appropriate information pertaining to our client's health, helps us optimize treatment.
    - Adhere to all safety protocols and guidelines established by the service provider.
        1. This information, along with other valuable information can be found in the caregiver handbook. Please do not hesitate to reach out with any questions or concerns regarding GVBSC's policies and procedures.
4. Behavior Management
    - Support GVBSC's behavior management policies and encourage your child to follow them.
    - Address behavioral concerns with the client in a positive and constructive manner as guided by your child's BCBA and behavioral team.
    - Collaborate with staff to develop strategies for managing your child's behavior if/when needed.
        1. Client success relies on all stakeholder's ability to work together and support consistency in implementation of the treatment plan. The ability to work together is essential to client success and is an expectation of ABA services.
5. Participation and Support
    - Encourage your child to participate fully in activities.
    - Support your child's efforts and celebrate their achievements.
    - Participate in caregiver training and assist with activities to the greatest extent possible, fostering a sense of community.
        1. GVBSC recognizes that optimal client progress and outcomes depend heavily on the collaborative efforts of the stakeholders involved in our clients' lives. GVBSC expects engagement and commitment to treatment from all stakeholders who participate regularly in the lives of the clients.
6. Confidentiality
    - Respect the privacy and confidentiality of all clients, families, and staff.
    - Do not share personal information or experiences of other clients or families without consent.
        1. GVBSC provides medically necessary services, therefore, follows the Health Insurance Portability and Accountability Act (HIPAA) to protect sensitive client health information from being disclosed without the client's consent or knowledge. In addition to protecting client information, HIPAA includes protections for employees and their dependents.

Consequences of Non-Compliance

- Failure to adhere to this Code of Conduct may result in a meeting with staff to address the concerns.
- Repeated or serious violations may lead to restrictions on participation or removal from services.

Conclusion

By following this Code of Conduct, caregivers and contribute significantly to a positive, safe, and nurturing environment for all children involved in services. We appreciate your cooperation and commitment to upholding these standards. Together, we can ensure a rewarding experience for everyone.

Life-saving Procedures and Medication Policy

At this time, GVBSC staff members are not permitted to administer any prescription medications a client may need, oral or topical. If a client requires prescription medication, due to a non-contagious illness or other need, caregivers are expected to administer the medication at the dosage prescribed prior to dropping their child off at the center. If a client requires medicine be administered during services, caregivers should make arrangements with their BCBA to support the caregiver's ability to bring their child's medicine during session and administer it.

That said, GVBSC recognizes that there may be times immediate lifesaving care is necessary and is fully committed to ensuring our client safety through rapid responding to medical emergencies. Below is the list of lifesaving care, separate from our standard CPR and first aid care, that designated GVBSC may use based in emergency situations or to prevent an emergency medical.

Procedures or medications that may be used by designated GVBSC staff in emergency situations:

- Emergency inhalers
- Epinephrine Pens
- Glucose monitoring device

If your child has a diagnosis or condition that may lead to the need for a lifesaving procedure listed above, please complete the life-saving medication consent form and provide all requested documentation to support our ability to keep your child safe.

Medication Delivery Consent

It is the policy of Grand Valley Behavior to gain parent/guardian permission before engaging in life-saving procedures, separate of CPR and first aid, or delivering lifesaving medication to a child.

This form may be used when a parent consents to GVBSC designated staff in administering life-saving over-the-counter products, certain prescription products, or certain procedures administered to their child in the clinical setting. These products include but are not limited to emergency inhalers, epinephrine pen, and continuous glucose monitoring (require individual approval).

- This form should NOT be used to meet the consent requirements for the administration of the following: medicated patches, and eye, ear, or nasal drops or sprays.
- One form must be completed for each product. Multiple products cannot be listed on one form.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:
7A. Frequency to be administered, include times of day if appropriate: ***OR*** 7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration):		
8A. Possible side effects: ☐ See product label for complete list of possible side effects (parent must supply) ***AND/OR*** 8B: Additional side effects:		
9. What action should the provider take if side effects are noted: ☐ Contact parent Other (describe):		
10A. Special instructions:		
11. Reason(s) for use (unless confidential by law):		
12. Parent name (please print):	13. Date authorized:	
14. Parent signature:		

GVBSC to complete this section

BCBA name:	
I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.	
Staff's name (please print):	Date received from parent:
Staff's signature: *X*	

Ointment Application Consent

It is the policy of Grand Valley Behavior to gain parent/guardian permission before applying sun cream or other ointment to a child.

This form may be used when a parent consents to having over-the-counter products administered to their child in the clinical setting. These products include, but are not limited to topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.

- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:
7A. Frequency to be administered, include times of day if appropriate: ***OR*** 7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration):		
8A. Possible side effects: ☐ See product label for complete list of possible side effects (parent must supply) ***AND/OR*** 8B: Additional side effects:		
9. What action should the provider take if side effects are noted: ☐ Contact parent Other (describe):		
10A. Special instructions:		
11. Reason(s) for use (unless confidential by law):		
12. Parent name (please print):	13. Date authorized:	
14. Parent signature:		

GVBSC to complete this section

BCBA name:	
I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.	
Staff's name (please print):	Date received from parent:
Staff's signature: *X*	

As the parent/guardian of the above-mentioned child, I understand that movies rated "PG" (Parental Guidance) by the Motion Picture Association of America (MPAA) may contain some material that parents might consider inappropriate for younger children. I acknowledge that PG-rated movies may include mild to moderate thematic elements, language, violence, and suggestive content.

I hereby give my permission for _____to watch PG-rated movies under the supervision of Grand Valley Behavior Services and Consulting or other authorized personnel during therapy hours.

I understand that Grand Valley Behavior Services and Consulting will select PG-rated movies with consideration for their educational or entertainment value and relevance to the program or curriculum.

By signing this waiver, I release and hold harmless Grand Valley Behavior Services and Consulting, its employees, and agents from any claims, damages, or liabilities arising from my child's viewing of PG-rated movies.

I have read and understood the content of this waiver and agree to the terms and conditions stated above.

I understand that I can revoke this waiver at any time.

Signature of Parent/Guardian: _____

Printed Name of Parent/Guardian: _____

Date:_____

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

Photo and Video Consent Form

I _____ give permission for Grand Valley Behavior; Service and Consulting (GVBSC) to take photos of videos of my child _____ during the time my child is enrolled in services. Photos and Videos taken of my child are for the sole purpose of aiding in my child's treatment. Additionally, I understand these files will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and for the purpose of educating and training GVBSC employees or other stakeholders as permitted via a release of information (ROI).

☐ Photo/Video of my child may be shared with GVBSC_____

☐ I do not with for GVBSC to share photos or video with any other person or organization.

Signature of Parent/Guardian: Date:

PO Box 2924
Grand Junction, CO 81502

(970) 317-7175

info@grandvalleybehavior.com

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

Transportation Waiver

Upon request Grand Valley Behavior may transport clients in employee's private vehicles to and from appointments or other community settings. Transportation is provided as a courtesy only in the course of providing regular services. This service is completely voluntary and Grand Valley Behavior will not transport your child without the request and written permission of a parent or legal guardian.

I recognize and acknowledge that Grand Valley Behavior is neither a common carrier nor in the business of providing transportation services to the public. I further recognize and acknowledge that there are certain risks of physical injury to vehicle passengers, and I voluntarily agree to assume the full risk of any injuries, damages, or loss, regardless of severity, that may be sustained as a result of participating in any and all activities connected with or associated with receiving transportation services, including, but not limited to, injuries, damages and loss arising out of negligent operation or supervision of the vehicle. I further agree to waive and relinquish all claims I may have (or accrue to me) against Grand Valley Behavior, including its officials, agents, and employees (hereinafter collectively referred to as "Grand Valley Behavior"). I do hereby fully release and forever discharge Grand Valley Behavior from any and all claims for injuries, damages or loss that may accrue arising out of, connected with, or in any way associated with said transportation services.

I have read and fully understand the above waiver and release of all claims.

PLEASE PRINT Client's Name: _____

Emergency contact #1:

Name: _____ Relationship to Client: _____

Home phone: _____ Cell phone: _____

Emergency contact #2:

Name: _____ Relationship to Client: _____

Home phone: _____ Cell phone: _____

Guardian's signature _____ Date_____

PO Box 2924
Grand Junction, CO 81502

Phn: (970) 317-7175
Fax: (970) 360-5542

info@grandvalleybehavior.com

GRAND VALLEY BEHAVIOR
SERVICES & CONSULTING

Holiday Schedule

Grand Valley Behavior Services and Consulting will be closed on the following holidays.

New Year's Day	January
Martin Luther King, Jr. Day	January
President's Day	February
Memorial Day	May
Juneteenth Day	June
Independence Day	July
Labor Day	September
Frances Xavier Cabrini Day	October
Veteran's Day	November
Thanksgiving Day	November
Christmas Day	December

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