Dear Perspective Client,

Thank you for your interest in our company. Please complete the Client Registration Form to provide sufficient information to assess how we can be of service. Additionally, there is a Client Referral Form that can be completed by your Child's diagnosing professional. With these two documents we can begin to assess an appropriate path towards beginning treatment. The below checklist has been provided to streamline the intake process. Please make sure all documents are completely filled out.

Checklist:

- Positive Steps ABA Client Registration Form
- Copy of Insurance Card(s) – Front & Back
- Psychological Evaluation – Preferably Comprehensive Diagnostic Evaluation w/ Diagnosis (Including Two or More of the Following Evaluations)
    - FAST
    - ADOS-R
    - CARS
    - DSM-V
    - Cognitive Evaluation
    - Language, Social, & Behavioral Evaluation
- Prescription on Doctor Letterhead Stating Diagnosis (ICD10 Code) & Recommendation for ABA Services.

Once you have completed the documents, you can turn them in in-person or you can email them, to Intake@PositiveStepsABA.com. We are available for phone consultation should you have any questions at (321) 413-3366.

Thank you again for your interest in our services and we look forward to working with you.

Sincerely,

Yasamin "Irene" Sarpoolaki, MA, BCBA
President

Requirements for ABA Services

1. Completed intake packet

_____ General Information

_____ Permission to Videotape and Photograph

_____ Client Registration Form

_____ Authorization to Release Information

_____ Authorization to Bill Insurance

_____ Informed Consent

_____ Confidentiality Act-Abuse Reporting Protocol

_____ Financial Responsibility

_____ HIPPA Service Agreement and Consent Form

_____ IEP

_____ ETR (If applicable)

_____ Psychological Evaluation– Preferably Comprehensive Diagnostic Evaluation

2. Pre-approval from insurance company (if applicable) is required prior to any evaluation, therapy, or other service being provided.

3. Intake

- Assessment with Positive Steps ABA BCBA or BCaBA
    - FBA, VB-MAPP, ABLLS-R, AFLS etc.

4. Parent Meeting – Development of treatment plan and review of reports, goals

5. Scheduling therapy sessions

6. Direct therapy will be conducted by a Registered Behavior Technician under the supervision of a BCBA or BCaBA

7. Monthly meetings to review progress

8. Quarterly/biannual assessments to continue to guiding instruction

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Mission

Our mission is to provide intensive treatment with the most effective, researched based therapy to make lasting changes in the lives of our clients. We believe in a total team approach to ensure that our clients are able to access the most appropriate services to meet their individual needs. Positive Steps ABA, LLC strives to provide the highest quality services for children and young adolescents with autism and other developmental disabilities. The emphasis is always client achievement and maximizing the individuals' potential in the home, school, and the community to create lasting change throughout their lives. Positive Steps ABA, LLC is dedicated to abide by the ethical standards outlined by the Behavior Analyst Certification Board.

Philosophy

Positive Steps ABA, LLC supports evidence-based treatment methods based in the principles and procedures of Applied Behavior Analysis including but not limited to Verbal Behavior strategies, Natural Environment Training (NET), Fluency Based Instruction, and Direct Instruction. A child's program is **individualized** to meet his/her needs. We first assure that each client meets eligibility requirements and appropriateness for admission to treatment. We then begin treatment planning by completing initial assessments including but not limited to Functional Behavior Assessments, Preference Assessments, VB-MAPP, AFLS, ABLLS, in order to guide instruction and develop the most effective treatment plan possible for each child. Each skill area/domain contains specific curriculum designed to increase each child's functioning and independence. Individual Treatment Plan goals will be established with the collaboration of parents, and/or the home school district, and/or other professionals that form the multidisciplinary team.

Contact Information

Yasamin "Irene" Sarpoolaki, MA, BCBA
President
YSarpoolaki@PositiveStepsABA.com
(321) 413-3366

An Overview of ABA/Verbal Behavior Approach to Therapy

ABA Therapy

Positive Steps ABA LLC utilizes the principles of Applied Behavior Analysis and develops individualized programs or treatment plans that target cognitive, speech, language, academic or school readiness, behavior management, play, and social skills. Each individualized program is based on the child's strengths and work to decrease skill deficits. Applied Behavior Analysis is the study of the functional relationship between one's behaviors and their environment. Data is collected on the stimuli that elicits, increases, decreases, or maintains the child's behavior. The data is analyzed and a treatment plan or an individualized ABA program is implemented. As the child's treatment progresses, data is collected and analyzed again to determine treatment effectiveness. The goal of a behavior analyst is to utilize behavioral contingencies to help the child learn more functional skills that can replace undesirable behaviors and improve quality of life. Positive Steps ABA LLC seeks to produce significant results enabling the child to adapt to their environment thus preparing them for a brighter future.

Individualized Programming/Development

Each child is unique and therefore we believe it is our job to design a behavior intervention program that is individualized to your child's specific needs. Our BCBA's and BCaBA's continually assess each child's needs and use Positive Steps ABA's extensive researched based curriculum to create a specialized program for each child. Our highly skilled staff members are trained in a wide range of ABA methods so that they have many options to find the intervention that works best to meet your child's specific needs.

Verbal Behavior Therapy

Verbal Behavior Therapy teaches communication using the principles of Applied Behavior Analysis and the theories of behaviorist B.F. Skinner. Verbal Behavior is the actions of a person that are reinforced by a listener. It is a way of understanding the different purposes of language (e.g., a child may use language to ask for things, or to label things in his environment). Each child has their own method of communication – words, signs, augmentative devices, pictures, etc., but all children need to learn to be effective communicators. All skills are examined comprehensively to see if they are emerging evenly across all operants. Most traditional language approaches differentiate between receptive (listener skills) and expressive (vocal) language. Skinner's functional analysis of verbal behavior further analyzes vocal behavior according to its function. Mand (request), Tact (label) and Intraverbal (talking about things in the absence of those things) are all components of "expressive language." Focusing on the reasons we say words rather than the form of the response allows us to more effectively teach functional language skills to children with Autism Spectrum Disorder.

The Verbal Operants:

- **Mand** = request (you say it because you want it)
- **Tact** = label (you say it because you see, hear, smell, taste, or feel something)
- **Intraverbal** = conversation, answering a question, responding when someone else talks (you say it because someone else asked you a question, or made a comment)
- **Echoic** = repeating what someone else says (you say it because someone else said it)

Other Operants:

- **Imitation** = repeating someone else's motor movements (you move because someone else moved the same way)
- **Listener Responding/Receptive** = following directions (you do what someone else asks you to do)

Our goal at Positive Steps ABA is to help our clients understand that *communicating* produces positive results.

Assessments - VB-MAPP, FBA, ABLLS-R, AFLS, etc.,

VB-MAPP - The VB-MAPP is a developmentally based criterion referenced assessment tool that was field-tested with typically developing children and children with ASD. The VB-MAPP assesses individual skills within each repertoire area, such as the echoic, mand, tact, intraverbal, etc. It also assesses the child's barriers to learning and contains a transition assessment which is to aide providers in making placement decisions about the level of inclusion or group instruction that may be appropriate for that learner. There are five components of the VB-MAPP (Milestones, Barriers and Transition Assessment, Task Analysis and Skills Tracking and Placement and IEP Goals), and collectively they provide a baseline level of performance, a direction for intervention, a system for tracking skill acquisition, a tool for outcome measures and other language research projects, and a framework for curriculum planning. Each of the skills in the VB-MAPP is not only measurable and developmentally balanced, but they are balanced across the verbal operants and other related skills.

FBA - A Functional Behavior Assessment is the primary tool used to identify and attempt to understand a child's behavior. It is a multidisciplinary approach that incorporates a number of techniques, sources of information, and strategies to understand the reasons behind problem behavior and to develop strategies or interventions to address the problem behaviors. The process involves documenting the antecedent (what comes before the behavior), behavior, and consequence (what happens after the behavior) over a number of weeks; interviewing teachers, parents, and others who work with the child; and manipulating the environment to see if a way can be found to prevent the behavior. This information is important because it leads the observer beyond the "symptom" (the behavior) to the student's underlying motivation to escape, "avoid," or "get" something, which is the root to all behavior. The findings from the FBA become the basis for the Behavior Intervention Plan.

ABLLS-R - The Assessment of Basic Language and Learning Skills - Revised is an assessment tool, curriculum guide, and skills-tracking system used to help guide the instruction of language and critical learner skills for children with autism or other developmental disabilities. The ABLLS-R contains a task analysis of the many skills necessary to communicate successfully and to learn from everyday experiences. It provides both parents and professionals with criterion-referenced information regarding a child's current skills, and provides a curriculum that can serve as a basis for the selection of educational objectives.

AFLS - The Assessment of Functional Living Skills (AFLS) is an assessment, skills tracking system, & curriculum guide for the development of essential skills for achieving independence. It can be used to demonstrate a learner's current functional skill repertoire & provide tracking info for the progressive development of these skills. The AFLS contains task analyses of the skills essential for participation in family, community, & work environments.

Other assessments are completed based on the individual needs of each child.

Behavior Intervention Plans

Behavior Intervention Plans are developed from a Functional Behavior Assessment. Behavior Intervention Plans increase the acquisition and use of new alternative skills, decrease the problem behavior and facilitate general improvements in the quality of life of the individual, his or her family, and members of the support team.

Social Skills Training

Positive Steps ABA, LLC provides social skills training to children with Autism Spectrum Disorder and other developmental disabilities. The focus of the program is to increase the child's overall ability to:

- Recognize and interpret verbal and non-verbal communication
- Develop appropriate peer relationships
- Assist individuals with improvement in social interactions by expanding their interest in age appropriate topics, toys and play skills
- Increase their ability to recognize others emotions
- The goal is to minimize the stress and anxiety when participating in social interaction.
- The program strives to provide the tools necessary for successful interpretation of social and communication skills.

Functional Communication Training

FCT is used to teach and establish replacement behaviors for inappropriate or harmful behaviors such as aggression, escape/elopement, non-compliance, etc. When a child is regularly engaging in disruptive, challenging behaviors the child is having difficulty communicating or meeting their wants and needs. Even for a verbal child, but particularly for a non-verbal child, behavior is a way

of communicating. It is our role to develop a comprehensive ABA program to replace challenging behaviors with more effective and efficient positive/ functional behaviors in order to get their needs and wants meet in a more socially acceptable manner.

Professional Development Training (Parent/Tutor/Teacher)

Positive Steps ABA, LLC offers a wide range of professional development trainings for parents, families and school districts in the area of Applied Behavior Analysis. Our workshops/trainings are available in full day sessions, half day sessions and evening sessions. Workshops and training can be tailored to meet your individualized needs for professional development. Please contact us for more information.

School Consulting

Positive Steps ABA, LLC offers consultation for individuals in their public and private school settings and also contract with schools who are seeking ABA services or consultation. Positive Steps ABA, LLC is able to provide services, which address needs such as assessments, behavioral assessments, teacher and staff training, modification of curriculum, social skills facilitation, program development, and ongoing supervision.

IEP Development and Support

Positive Steps ABA, LLC can provide on-going collaboration throughout the Individualized Education Plan (IEP) process, including the construction of IEP goals and objectives, assisting in the implementation of the goals in the home and school settings, and reporting of progress.

Parent Guidelines

Your cooperation on the following is greatly appreciated to assist us in working with your child effectively and efficiently:

- A parent or responsible adult must be in the home during therapy sessions.
- Your child should be dressed and fed prior to therapist arrival unless these skills are being addressed in the program.
- If sessions are in the home, the area being used for therapy must be a comfortable temperature, well lit and relatively free of distractions. It is important that we are able to conduct the session in a professional manner with materials ready and limited access to competing reinforcers (i.e. toys that are not used during the therapy session).
- The therapist must wait 15 minutes if child is not there at the therapy time and then is permitted to leave.
- The therapist will call the family if they are going to arrive more than 5 minutes late.
- A therapist cannot change appointment times without agreement with the family.
- If your family is planning an extended vacation (more than 2 weeks), please inform the therapist and supervisor. We will continue to reserve the spot for your child, but cannot guarantee that your child will work with the same therapist.
- In case of an accident or unusual incident, the therapist should complete an incident form and family and Chief Clinical Officer will be informed within 1 working day.
- Sickness. *Please notify the therapist, as much in advance as possible, at least the night, before the scheduled session if you know that your child (or other children in your home) will not be able to participate in the program the next day due to illness.* Sickness includes, but not limited to the following:
  - Temperature above 100
  - Communicable Disease
  - Hand/Foot/Mouth
  - Vomiting
  - Measles, Mumps, Chicken Pox
  - Diarrhea
  - Pin Worm
  - Strep Throat
  - Lice
  - Rash
  - Pink Eye

Parent/ Guardian Initials	Date

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Parents are asked to use the same guidelines used in a school – if a child **(or sibling)** is too sick to attend school, he or she is too sick to participate in his/her therapy session.

Therapy will resume as soon as the child's doctor clears him/her of being contagious or the remedy is completed. If a therapist arrives at the home and the child is sick, the therapist will not be able to work with your child.

- The therapist is NOT allowed to take a child in their automobile.
- Parents and consultants/therapists should be respectful and courteous to each other. Open communication between parents and consultants/therapists is essential to the establishment of a successful program for the child. If there are any problems or concerns, please contact the Chief Clinical Officer immediately.
- Please understand that all information shared is HIPPA protected, it is essential that every Positive Steps ABA, LLC employee respects and maintains each client's right to confidentiality regarding his or her treatment and all personal information. **All HIPPA laws apply.** Please do not ask about another clients program or treatment, as this information will not be discussed and could possibly lead to the dismissal of your child from the program.

Parent/ Guardian Initials	Date

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Scheduling and Sessions

Each client will have a Board Certified Behavior Analyst or Board Certified assistant Behavior Analyst as the lead supervisor for their treatment. A Behavior Technician will provide direct 1:1 therapy in the designated setting. Each Behavior Technician is registered at a minimum and has experience providing services to children with Autism.

Sessions for in-home ABA are usually scheduled in two to three hour blocks. A parent/legal guardian or adult over the age of 18 is required to be present and available in the home throughout the therapy session(s). Except in cases of emergency, 24 hour's notice is required for all cancelled appointments. We request that families give us at least two week's notice on significant changes in their plans for in-home ABA sessions scheduling to facilitate consistency in service delivery.

The universal standard for therapy that the last 15 minutes of each session is devoted to data collection, note writing, material preparation/organization for the following session and discussion of session with the parent.

Service Agreement and Consent Form

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operation. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires we obtain your signature acknowledging we have provided you with this information. Although these documents are long and sometimes complex, it is very important you read them carefully and you ask questions regarding the procedures. When signing this document, it will also represent an agreement between our clients/caregivers and Positive Steps ABA, LLC. You may revoke this agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed by your health insurer to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations. If you have any questions or concerns, please feel free to bring them to our attention.

Parent/ Guardian Initials	Date

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Services and Discharge

Positive Steps ABA, LLC offers a full service ABA program. To determine the program needed for a client we initially complete an assessment to determine whether a client would benefit from our services. After it has been determined that our services are needed, a BCBA is appointed as the team leader and develops a treatment plan based on the findings of the assessment.

The treatment plan includes general and specific goals with time frames for completion. The treatment plan also includes a scheduled reassessment generally six months from the time the treatment plan is developed. The treatment plan is then implemented by the BCBA who supervises Behavior Technicians on proper implantation of the treatment plan.

As needed, the program is adjusted by a BCBA to accommodate the client's progress. If the treatment plan is over challenging the plan will be modified with lower intensity goals. As the client advances through the program more challenging goals can be added to the plan. If after adjusting the treatment plan and following the updated plan we may determine our services is not the proper treatment for the client. If such a determination is made, we will follow our discharge and referral protocol.

Once the client has attained the level of development similar to a typical developing child, the client will be put on a maintenance program until the BCBA determines services will no longer benefit the client. Being a sudden stop in services can be detrimental to the skills acquired, the discharge from services is done over a long period of time to achieve a smooth transition.

Appointments

Except for rare emergencies, we will see you (or your child) at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitates the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you speak to our staff personally and give as much notice as possible to cancel or reschedule. This will allow us to offer your time to another person. You may be charged the standard hourly rate ($50) for appointments missed or cancelled with less than 24 hours advance notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

Confidentiality, Records, and Release of Information

Services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals or agencies.

Parent/ Guardian Initials	Date

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Family Engagement

Positive Steps ABA, LLC, strives for excellence in its ABA program and an integral component to achieve that goal is family involvement. Positive Steps ABA, LLC requires caregivers carry over the therapy being implemented and record data for specific programs as outlined in the client treatment plan.

If the Client/Family refuses involvement in the treatment plan, as a last resort services may be suspended or terminated based on the severity of the lack of involvement. Positive Steps ABA, LLC wants to help all clients we interact with but without the client/family involvement our treatment plans will not be as effective as possible.

To Protect the Client or Others from Harm

If we have reason to suspect that a client or other minor is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions, which could include notifying the police, and intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

Professional Consultations

Behavior Analysts routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal. We will inform clients of these consultations. If you want us to talk with or release specific information to other professionals with whom you are working, you will need to sign an authorization specifying what information can be released and with whom it can be shared.

Parent/ Guardian Initials	Date

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Supervision Requirements for Private Pay Clients

- **BCBAs** do not require supervision.
- Our BCaBAs are provided with supervision by a **BCBA** however, our private pay clients are not financially responsible for this supervision.
- Programs implemented by Behavior Technicians require 1 hour of supervision per every 8 hours of direct instruction.

Miscellaneous Services

Additional Services are offered that may include, but not limited to, phone consultation, co-treatments, attendance of school meetings and IEPs, attendance of psychological evaluations, etc.

Cancellation and Late Fees

- Cancellations with less than a 24 hour notification: $50 per appointment (Please refer to our cancellation policy for more details)
- Arrival Late Fees: If a patient is picked up more than 5 minutes late of their scheduled session, a $1.00 per minute late will be charged.

Change in Fee Structure

The fee structure for all services rendered through Positive Steps ABA, LLC. is subject to change. Clients will be made aware of such modifications 30 calendar days prior to the effective date of any changes.

Payments

Payment Options. We accept the following forms of payment:

- Cash
- Check

Invoices are billed on or about the first of each month. Payment is expected by the last day of the month. If payment cannot be paid, please contact Yasamin Sarpoolaki at 321-413-3366 so that a payment plan can be agreed upon.

Late Payments: If the President is not contacted, a $25 late fee will be assessed on the first of each month that an invoice is not paid.

Parent/ Guardian Initials	Date

Professional Records

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in one set of professional records. The Clinical Record includes information about reasons for seeking our professional services; the impact of any current or ongoing problems or concerns; assessment, consultative, or therapeutic goals; progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Personal notes are taken during supervision sessions by the Behavior Technician. While the contents of personal notes vary from client to client, most are anecdotal notes related to progress and future goals, reference to conversations, and hypotheses of the professional. These Personal Notes are kept separate from the Clinical Record are not available to you and cannot be sent to anyone else, including the insurance company. Your signature below waives all rights, now and in the future, to accessing these records in any form under any circumstances. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Patient's Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints made about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

Contacting Us

Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends.). If you are difficult to reach, please leave your availability within the message. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms described above.

_____ Client's Name	_____ Date
_____ Parent/Guardian Printed Name	_____ Parent/Guardian Signature

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Behavior Analyst Services Expectations

Client's Name: _____ DOB: _____

Behavior Analyst Description:

A Behavior Analyst provides community-based therapy support services. The Behavior Analyst provides an assessment for the consumer along with the development of a plan of care and insures the implementation of the plan.

Behavior Analyst Responsibilities:

- If requested and approved a Functional Behavior Assessment (FBA) will be completed within 30 days of receipt of the Personal Service Authorization (PSA).
- Development of a Behavior Analysis Service Plan (BASP) that is incorporated into the Individual Service Plan (ISP) will be due within 90 days from receipt of the PSA.
- Provides services only within the margins of the PSA.
- Submit applicable plans to the Local Reviewing Committee, completes revisions and submits updates as necessary and required.
- Implements the BASP as well as train and monitor caregivers.
- Collects ad analyzes data received from caregivers.
- Complete Case Note/ Client Contact Log with signed confirmation of services.
- Complete Quarterly Service Summaries and Annual Reports in relation to the Support Plan effective date, to include Monthly Graphs.
- Submit all Summaries and Reports to Local APD office each month by all required deadline.
- Active member of the consumer's treatment team.
- Attendance at the consumer's ISP meeting when requested.
- Regular correspondence with the consumer's Support Coordinator and relevant caregivers.
- Coordinate appointments for service delivery.
- Provide on-site services in the home, community, work place, or ADT.

By signing below I am indicating that I fully understand the role my Behavior Analyst has in providing me with exceptional services. I have also had the responsibilities of the Behavior Analyst explained to me.

Parent/ Guardian Signature	Date
Behavior Analyst Signature	Date

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Assistant Behavior Analyst and Registered Behavior Technician Services Expectations

Client's Name: _____ DOB: _____

Assistant Behavior Analyst and Registered Behavior Technician Description:

Assistant Behavior Analyst and Registered Behavior Technician provide community-based therapy support services. Assistant Behavior Analyst and Registered Behavior Technician work with a Behavior Analyst to implement the behavior plan, collect data, and train caregivers.

Assistant Behavior Analyst and Registered Behavior Technician Responsibilities:

- Provides services only within the margins of the Personal Service Authorization (PSA).
- Implements the Behaviors Analysis Service Plan (BASP) as well as trains and monitors caregivers.
- Complete Case Note/ Client Log with signed confirmation of services.
- Complete Quarterly Service Summaries and Annual Reports in relation to the Support Plan effective date, to include Monthly Graphs.
- Submit all Summaries and Reports to Local APD office each month by all required deadline.
- Active member of the consumer's treatment team.
- Attendance at the consumer's ISP meeting when requested.
- Regular correspondence with the consumer's Support Coordinator and relevant caregivers.
- Coordinate appointments for service delivery.
- Provide on-site services in the home, community, work place, or ADT.

By signing below I am indicating that I fully understand the role my Assistant Behavior Analyst and Registered Behavior Technician has in providing me with exceptional services. I have also had the responsibilities of the Behavior Analyst explained to me.

Parent/ Guardian Signature	Date
Assistant Behavior Analyst or RBT Signature	Date

Client Bill of Rights

Client's Name: _____ DOB: _____

- I have the right to dignity, privacy, and humane care, including the right to be free from sexual abuse in my residence.
- I have the right to practice my faith.
- I have the right to receive services which protect my personal liberty and those services will be provided in the least restrictive conditions necessary to achieve the purpose of treatment.
- I have the right to participate in a program to promote my educational and/ or training goals without prejudice of age or disability.
- I have the right to sex education, marriage, and family planning when applicable.
- I have the right to social interaction and participation in community activities.
- I have the right to physical exercise and recreational activities.
- I have the right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse, or neglect.
- I have the right to consent to or refuse treatment, subject to the provisions of f.s.s. 393.12(2)(a) or chapter 744.
- I have the right to receive benefits or participate in activities which receive public funds.
- I have the right to vote.
- I have the right to unrestricted communication; mail, telephones, visitation, personal possessions (clothing, personal effects), monies (in accordance to f.s.s. 407.12. Included in my right to have personal possessions will be the access to individual storage space for my private use.
- I have the right to appropriate medical and dental care.
- I have the right to humane discipline.
- No treatment plan of behavior plan will be used which contains the use of noxious or painful stimuli.
- My records will remain confidential.

By signing below I am indicating that I fully understand the Client Bill of Rights and that a copy was provided to me. I have also had the Client Bill of Rights explained to me.

Parent/ Guardian Signature	Date
Behavior Analyst Signature	Date

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

First Aid Release Form

Client's Name: _____ DOB: _____

I agree to allow personnel of Positive Steps ABA, LLC to administer simple first aid in the form of cleaning and bandaging a cut, burn, or scrape. I understand that Positive Steps ABA, LLC personnel are not authorized to administer medications and medical attention beyond simple bandaging. Any injury that occurs will be referred out to the nearest hospital and/ or critical care facility or by dialing 911. Positive Steps ABA, LLC personnel are not authorized to transport injured clients.

By signing below I am indicating that I fully understand the First Aid Release Form and that a copy was provided to me. I have also had the First Aid Release Form explained to me.

Parent/ Guardian Signature	Date
Behavior Analyst Signature	Date

Steps for Submitting a Grievance

Client's Name: _____ DOB: _____ Date: _____

Explanation of step for filing a grievance:

1. Notify Positive Steps ABA LLC President, Yasamin Sarpoolaki, of the nature and issue at hand.
    a. May be reached at (321)413-3366.
    b. May be reached via email at YSarpoolaki@PositiveStepsABA.com
2. Provide any documentation that you have of the issues at hand.
3. Positive Steps ABA LLC will do everything to satisfy our clients in any way possible, and promise to address your concern in a timely and effective manner.

Parent/ Guardian Signature	Date
Behavior Analyst Signature	Date

Grievance Report

Client's Name: _____ DOB: _____ Date: _____

Name of person requesting review:
Relationship to client:

Nature of complaint:

_____
_____
_____
_____

Resolution:

_____
_____
_____
_____

Date of resolution:
Date sent to:
Requestor:
WSC:
Others:

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Title VI

Client's Name: _____ DOB: _____ Date: _____

Dear Positive Steps ABA, LLC, Client and Parent/Guardian,

As a client of Positive Steps ABA, LLC, you are protected against discrimination by Title VI of the Civil Rights Act of 1964. Title VI requires that no person in the United States of America shall, on the grounds of race, color, sex, or national origin, be excluded for the participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which a providing company receives federal financial assistance.

Positive Steps ABA, LLC, assures full compliance with Title VI of the Civil Rights Act of 1964, the Civil Rights Restoration Act of 1987, and related statues and regulations in all programs and activities provided.

Any client who believes they have been distressed by an unlawful discriminatory practice under Title VI has a right to file a formal complaint. Any such complaint must be in writing and filed with Positive Steps ABA, LLC, President within on hundred eighty (180) days following the date of alleged discriminatory occurrence.

Title VI Complaint Forms can be obtained and/ or to register a Title VI complaint please contact our Human Resources at Admin@PositiveStepsABA.com.

Sincerely,

Yasamin "Irene" Sarpoolaki, MA, BCBA
President

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Title VI Receipt Form

Client's Name: _____ DOB: _____

By signing below I verify that I have received the Title VI letter from Positive Steps ABA, LLC.

Parent/ Guardian Signature	Date
Behavior Analyst Signature	Date

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Permission to Photograph

Client's Name: _____ DOB: _____

I give permission and consent for Positive Steps ABA, LLC to photograph my child and/ or myself during the time my child is enrolled in services. I understand these photographs may be used in educational training presentations.

Parent/ Guardian Printed Name	Date

_____
Parent/Guardian Signature

In addition to the above, I also give permission for Positive Steps ABA, LLC to use full-face photographs of my child for promotional or marketing materials.

Parent/ Guardian Printed Name	Date

_
_____
Parent/Guardian Signature

Permission to Videotape or Audiotape

I give permission and consent for Positive Steps ABA, LLC to videotape and/or audio tape my child and/or myself during the time my child is enrolled in services. I understand these tapes 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 also for the purpose of education and training for Positive Steps ABA, LLC.

Parent/ Guardian Printed Name	Date

_____
Parent/Guardian Signature

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Client Registration Form

Client Information:

Last Name:	First Name:	Middle Name:
Patient SS#:	Patient DOB:	Sex: ☐Male ☐Female
Address:		Apt#:
City:	State:	Zip Code:
Home#:	Cell#:	Email:
Diagnosis:	Diagnosis Code (If Known):	
Name of School:		Grade:

Parent/Guardian Information:

Mothers Last Name:	Mothers First Name:	
Mothers SS#:	Mothers DOB:	
Mothers Address:		Apt#:
City:	State:	Zip Code:
Home#:	Cell#:	Email:
Is it ok to leave a voice message on your home or cell? ☐Yes ☐No		
Occupation:	Employer:	

Fathers Last Name:	Fathers First Name:	
Fathers SS#:	Fathers DOB:	
Fathers Address:		Apt#:
City:	State:	Zip Code:
Home#:	Cell#:	Email:
Is it ok to leave a voice message on your home or cell? ☐Yes ☐No		
Occupation:	Employer:	

Insurance Information

Please make sure to thoroughly and accurately completely the below insurance information fields. If your child has Medicaid, we will need the Medicaid ID number and the Gold Card number.

Medicaid Insurance Policy

Name of Insurance:
Medicaid ID#:
Gold Card#:

Primary Insurance Policy (United Healthcare, Cigna, Aetna, Humana–Tricare East, etc.)

Please make sure to thoroughly and accurately completely the below insurance information fields. Do not complete this section if the client has a Medicaid insurance plan.

Name of Insurance:
Member ID#:
Group#:
Policy Holder's Name:
Policy Holder's DOB:
Policy Holder's Employer:

Secondary Insurance Policy (United Healthcare, Cigna, Aetna, Humana–Tricare East, etc.)

Please make sure to thoroughly and accurately completely the below insurance information fields only if you have a secondary insurance policy. Do not complete this section if the client has a Medicaid insurance plan.

Name of Insurance:
Member ID#:
Group#:
Policy Holder's Name:
Policy Holder's DOB:
Policy Holder's Employer:

Siblings/Household Members (Other than parent/guardian)

Name:
Date of Birth:
Relationship to Client:

Name:
Date of Birth:
Relationship to Client:

Name:
Date of Birth:
Relationship to Client:

Name:
Date of Birth:
Relationship to Client:

Name:
Date of Birth:
Relationship to Client:

Emergency Contact Information

Name:
Phone Number:
Relationship to Client:

Name:
Phone Number:
Relationship to Client:

Other Services Provided (Speech/PT/OT, etc.)

Name of Provider:	
Services Provided:	Times per Week:

Name of Provider:	
Services Provided:	Times per Week:

Name of Provider:	
Services Provided:	Times per Week:

Diagnosis

Primary Diagnosis 1:	Diagnosis Date(s):
Diagnosing Professional:	

Primary Diagnosis 2:	Diagnosis Date(s):
Diagnosing Professional:	

Primary Diagnosis 3:	Diagnosis Date(s):
Diagnosing Professional:	

Primary Diagnosis 4:	Diagnosis Date(s):
Diagnosing Professional:	

Medical Conditions (if any):
Allergies:
Diagnosing Professional:
Special Diet Information:

Current Medications (if any)

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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ABA Services Requested

___ Home Based ___ Clinic Based ___ School Based ___Social Skills Group

Available Service Times

Monday:	Tuesday:	Wednesday:	Thursday:
Friday:	Saturday:	Sunday:	

What are your goals and/or expectations for the services requested?

_____

_____

_____

_____

Problem Behavior Information

Behavior (Please describe)	**Frequency** (hourly, daily, weekly, less often, more often, etc.)	**Duration** (how long does the behavior occur)	**Severity** Mild – Disruptive but little risk Moderate- property damage or minor injury Severe- Significant threat to health or safety

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Child's Educational Background

School: _____ Grade: _____

☐ Home School ☐ Life Skills ☐ Emotional Support	☐ General Education ☐ Learning Support ☐ Speech/Language	☐ Autistic Support ☐ Private School ☐ Public School

Contact Name: _____ Phone Number: _____

Please attach the most recent copy of your child's IEP, RR, ETR, FBA and/or BIP.

Insurance Parent/ Guardian Authorization

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Positive Steps ABA, LLC. I understand that I am financially responsible for any balance. I also authorize Positive Steps ABA, LLC or insurance company to release any information required to process my claims and to establish service eligibility/authorizations.

Client Name	Client DOB

Parent/ Guardian Printed Name	Date

_____
Parent/Guardian Signature

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

AUTHORIZATION FOR RELEASE OF INFORMATION – Page#1

Client Name: _____ DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the supervision of Positive Steps ABA, LLC. This authorizes the release or ability to obtain protected health information concerning the above named client. Health information may relate to the clients past, present, or future physical or mental health condition, and the provision of the clients health care, or payment for the clients health care services. This information may be disclosed to or obtained from the following:

Agency Name/ Contact Person:

OR

Doctor's Name and Practice:
Doctor's Phone Number:
Doctor's Mailing Address:
City, State, Zip:
Delivery Method: ☐ Mail ☐ Phone ☐ Fax ☐ Email

I authorize ☐ ALL health information to be disclosed OR only the following information is/are authorized for disclosure (check all to be released).

☐ Individual Education Plan	☐ Speech/ Language Eval.	☐ Client Information Sheet
☐ Psych Educ. Assessment	☐ Hearing Screening	☐ Individualized Treatment
☐ Report Cards/ Transcripts	☐ Medical History	☐ Treatment Plan Reviews
☐ Behavior Report	☐ Immunization Record	☐ Psychosocial Evaluation
☐ Special Report	☐ Neurology Report	☐ Behavioral Program
☐ Psychological Evaluation	☐ Psychiatric Evaluation	☐ Discharge Summary
☐ Med Management Visits	☐ Progress Notes	☐ Progress Summary

This release will remain in effect for one (1) year, unless otherwise stipulated or revoked in writing. From _____(MM/DD/YYYY) To _____MM/DD/YYYY).

Purpose of release: ☐ At the request of the individual ☐ Assessment ☐ Treatment

Parent/ Guardian Initials	Date

AUTHORIZATION FOR RELEASE OF INFORMATION – Page#2

Other Information:

- I understand that Positive Steps ABA, LLC cannot guarantee that the recipient will not re-disclose my health information to a third party. The recipient may not be subject to federal laws governing privacy health information.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Positive Steps ABA, LLC.
- I understand that I may revoke this authorization in writing at any time, however, I cannot revoke authorization for action that has already been taken.

A copy of this release shall be valid as the original.

THIS CONSENT EXPIRES ONE YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.

Parent/ Guardian Printed Name	Date

_____

Parent/Guardian Signature

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

AUTHORIZATION TO BILL INSURANCE

Client Name: _____ DOB: _____

I, _____, hereby give my consent for Positive Steps ABA, LLC to bill my/my child's insurance carrier for the services rendered to my child by the above mentioned provider. In addition, I agree to pay Positive Steps ABA, LLC any deductible or uncovered charge in accordance with the client's health care plan.

Parent/ Guardian Printed Name	Date

_____
Parent/Guardian Signature

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INSURANCE CARRIER

I understand that my express consent is required to release any health care information relating to assessment and treatment. I, _____, hereby give my consent for Positive Steps ABA, LLC to release medical and other relevant information to the client's insurance carrier as required by the client's insurance carrier to process medical billings.

Parent/ Guardian Printed Name	Date

_____
Parent/Guardian Signature

Informed Consent for Treatment Page# 1

Client Name: _____ DOB: _____

I, _____, agree to have my child _____ evaluated/treated through Positive Steps ABA, LLC. I understand that these services are based on an applied behavior analysis (ABA) model and will be provided by a professional trained in ABA. I understand that state laws may require that confidentiality be broken under certain circumstances, specifically, if I am judged by the behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected child abuse. The specific terms of this Informed Consent for Treatment are as follows:

- Positive Steps ABA, LLC is providing services including, but not necessarily limited to behavior analysis services, assistant behavior services, evaluation, program development, and treatment for the above named client.
- Positive Steps ABA, LLC will provide the aforementioned services in a professional manner and will take every precaution within reason to insure the safety of the client.
- The undersigned herby acknowledges the potential risk of inadvertent injury to the client. Positive Steps ABA, LLC has informed the undersigned that treatment strategies are often play-based or interactive in nature and accordingly, can potentially pose risk of unintended injury to the client.
- The undersigned hereby acknowledges the potential risks of injury based on the strategies implemented by Positive Steps ABA, LLC and consents to the same despite the disclosed risks. Furthermore, the undersigned hereby waives, on behalf of the undersigned as well as the client, together with the heirs, devisees, or assignees of the undersigned or the client, any and all liability for personal injury, physical, or otherwise, which may be incurred by the client as a result of the provision of services.
- The undersigned acknowledges and agrees that the execution of this form, and the promises, and conditions set forth herein, is partial consideration for the provision of services to the client by Positive Steps ABA, LLC.
- The undersigned acknowledges and agrees that if the status of legal guardian should change, they will immediately notify Positive Steps ABA, LLC, of the name, address, and telephone number of the person(s) who has assumed guardianship of the above named client.
- The undersigned acknowledges and agrees that they have legal authority to consent to treatment, release information, and all leagal issues involving the above named client. Upon request, I will provide Positive Steps ABA, LLC, with proper legal documentation to support this claim.

I also understand that Positive Steps ABA, LLC specializes in the evaluation and treatment of problem behaviors as well as skill acquisition, and if Positive Steps ABA, LLC is unable to meet my particular needs, I will be referred to an appropriate agency or individual.

Services: Positive Steps ABA, LLC implements the Applied Behavior Analysis for its services. A variety of techniques are integrated and utilized during treatment. You will be encouraged to

Informed Consent for Treatment Page# 2

Client Name: _____ DOB: _____

practice various skills introduced in sessions. A treatment plan with specific goals will be explored and updated according to treatment plan schedules. Recommendations for additional treatment and/or intensive treatment may be made, if needed. **When a client is a minor under the age of 14,** parent involvement is required during all visits with the Client. Information will be limited to accommodate confidentiality with children of all ages. Family involvement is an important part of treatment. Children under the age of 18 will require a parent's signature (or legal guardian) to receive any form of treatment.

Concerns about services may be directed to Yasamin Sarpoolaki, President at 321-413-3366 or YSarpoolaki@PositiveStepsABA.com

By signing below, I verify that I have read and understood the above Informed Consent for Treatment, agree to adhere to it, and wish to have Positive Steps ABA, LLC provide services and that the provision of services will be contingent upon adherence to this agreement and full participation by the caregiver/ guardian. If at any time there is not full participation and cooperation by the caregiver/ guardian, I understand Positive Steps ABA, LLC may terminate services following notice of thirty (30) days. I also understand that I may discontinue services at any time and will be held accountable to pay for services rendered up to that point.

Parent/ Guardian Printed Name	Date

_____
Parent/Guardian Signature

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Confidentiality Act – Abuse-Reporting Protocol

Client Name: _____ DOB: _____

Parent/Guardian Name: _____

I understand all information related to the above-named client's assessment and treatment must be handled with strict confidentiality. No information related to the client, either verbal or written, will be released to other agencies or individuals without the express written consent of the client's legal guardian. By law, the rules of confidentiality do not hold under the following conditions:

1. If abuse or neglect of a minor, disabled, or elderly person is reported or suspected, the professional involved is mandated to report it to the Florida Department of Children and Families for investigation at 1-800-96-ABUSE.

2. If, during the course of services, the professional involved receives information that someone's life is in danger, that professional has a duty to warn the potential victim.

3. If our records, our subcontractor records or staff testimony are subpoenaed by court order, we are required to produce requested information or appear in court to answer questions regarding the client.

I understand this protocol and by signing acknowledge my agreement with the stipulations in this protocol.

Parent/ Guardian Printed Name	Date

_____
Parent/Guardian Signature

(321) 413-3366 (321) 306-2880 Admin@PositiveStepsABA.com www.PositiveStepsABA.com

Financial Responsibility

Client Name: _____ DOB: _____

For clients who do not have insurance:

- Clients who do not have any insurance coverage are expected to pay on a monthly basis. An invoice will be sent at the beginning of the month following services with an expectation payment is received by the end of the month. A sliding scale may be implemented to accommodate any financial difficulties on a case-by-case basis.
- Clients who are currently covered by insurance: The client is responsible to provide valid insurance information, and should provide their insurance card each visit.
- It is important for you to make sure we are in-network and we are currently a provider with your insurance company.
- If we are currently a provider with your insurance company, the necessary forms will be completed and submitted, and secondary insurances will be billed when applicable.

In Network Plans:

- The client is responsible to pay any co-payment or any portion of the charges as specified by the plan at the time of the visit.
- Any medical services not covered by an individual's insurance plan are the client's responsibility and payment in full is due at the time of the visit. Specific coverage issues should be addressed by the insurance company's member services department (telephone number is on the card).

If you are covered by an HMO or Managed Care Plan:

- The client is responsible to pay any co-payment or any portion of the charges as specified by the plan mentioned above.
- The client is responsible to ensure that any required referrals for treatment are provided to the practice at the time of the visit. Visits may be rescheduled, or the patient may be financially responsible due to the lack of the referral.
- WE reserve the right to charge for the completion of forms and letters. For example, insurance, or different programs, and the copying of records.

Any outstanding balance either not paid in full or under a payment plan agreement can be transferred to an outside collection agency. A "no show"/late cancellation fee may be charged to clients who do not provide at least 24 hour notice for cancelling scheduled appointments or who fail to keep scheduled appointments without calling to notify the scheduling secretary or clinician.

Parent/ Guardian Printed Name	Date

_____
Parent/Guardian Signature

Health Insurance Portability and Accountability Act (HIPAA)
Notice of Privacy Practices

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

Positive Steps ABA, LLC understands we collect private and/or potentially sensitive medical information about each client and/or the client's family. We call this information "protected health information." This notice explains the client's privacy rights and addresses how Positive Steps ABA, LLC may use and disclose protected health information. Positive Steps ABA, LLC does not use or disclose protected health information unless permitted or required to do so by law. Positive Steps ABA, LLC must adhere to laws aimed at securing the privacy of the client's protected health information. These laws are known as the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. When we do use or disclose protected health information, we will make every reasonable effort to limit its use or the level of disclosure to the minimum we deem necessary to accomplish the intended purpose. Please note that the privacy provisions articulated in this notice do not apply to health information that does not identify the client or anyone else. For more information on Positive Steps ABAs, LLC privacy practices, or to receive another copy of this notice, please contact:

Positive Steps ABA, LLC
Admin@PositiveStepsABA.com
(321) 413-3366

Protected Health Information

Protected health information is information about the client relating to a past, present, or future mental health condition, or treatment or payment for the treatment that can be used to identify the client. This includes any information, whether oral or recorded in any form, that is created or

received by Positive Steps ABA, LLC. This also includes electronic information and information in any other form or medium that could identify the client. Examples of information that can identify a client include, but are not limited to the following:

Client's Name
Telephone Number
Address
Date of Birth
Social Security Number
Service State/End Date
Diagnosis

Uses and Disclosures of Health Information for Treatment, Payment, and Health Care Operations

1. Treatment, Payment, and Health Care Operations

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

a. Treatment

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

b. Payment

We may use and disclose the client's protected health information so we may bill and collect payment from the client, an insurance company, or another party for services Positive Steps ABA, LLC provided to the client. We may also inform the client's health plan provider of treatment we intend to administer to obtain prior approval or to determine whether the client's plan will pay for the treatment.

c. Health Care Operations

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

2. Special Circumstances

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

a. Appointment Reminders

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

b. Treatment Information

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

c. Satisfaction Surveys

We may use and disclose the client's protected health information to contact him/her about Positive Steps ABA, LLC satisfaction surveys.

3. Uses and Disclosures You Can Limit

a. Positive Steps ABA, LLC Client Directory

Unless the client notifies us that he/she objects, we may include certain information about him/her in Positive Steps ABA, LLC Client Directory in order to respond to inquiries and disseminate information more efficiently. This directory is accessed by Positive Steps ABA, LLC staff who may or may not be involved in the client's treatment.

b. General Notification

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

WHEN WRITTEN AUTHORIZATION IS REQUIRED

Other than for the range of purposes previously identified in this notice, we will not use or disclose the client's protected health information for any purpose unless the client provides us with specific written authorization to do so. If the client grants us authorization, the client can still withdraw this authorization at any time, though the authorization must be revoked in writing.

In order to withdraw the authorization, the client must deliver an email to:

Positive Steps ABA, LLC
Admin@PositiveStepsABA.com

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

THE CLIENT'S RIGHTS REGARDING THE CLIENT'S HEALTH INFORMATION

The client has certain rights regarding his/her health information, which are listed below. In each of these cases, if the client wants to exercise his/her rights, the client must do so in writing by completing a form the client can obtain from Positive Steps ABA, LLC . In some cases, we may charge the client for the costs of providing materials to the client. The client can get information about how to exercise his/her rights and about any costs that we may charge for materials by contacting us.

1. Right to Inspect and Copy

With some exceptions, the client has the right to inspect and get a copy of the client's protected health information that may be used to make decisions about the client's care. We may deny the client's request to inspect and/or copy information in certain limited circumstances, and, if we do this, the client may ask that the denial decision be reviewed.

2. Right to Amend

The client has the right to amend his/her health information maintained by Positive Steps ABA, LLC, or used by us to make decisions about the client. We will require that the client provide a

reason for the request, and we may deny the request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment), (b) is not part of the health information we keep, (c) is of a type the client would not be permitted to inspect and copy, or (d) is already accurate and complete.

3. Right to an Accounting of Disclosures

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

4. Right to Request Restrictions

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

5. Right to Request Confidential Communications

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

6. Right to a Paper Copy of This Notice

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

Questions, Suggestions, and/or Complaints

If the client has any questions about this notice, he/she should contact:
Positive Steps ABA, LLC - Admin@PositiveStepsABA.com - (321) 413-3366

If the client believes his/her privacy rights have been violated, the client may file a complaint with Positive Steps ABA, LLC using the contact information provided above. To file a complaint with the Secretary of the Department of Health and Human Services, call (877) 696-6775.

If the client believes his/her privacy rights have been violated, contact:
Office of Civil Rights, Medical Privacy Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. HHH Building, Room 509H
Washington, D.C. 20201
Phone: (866) OCR-PRIV (627-7748) TTY: (886) 788-4989 www.hhs.gov/ocr
The client will not be penalized for filing a complaint and the client will continue to have the same access to Positive Steps ABA, LLC services.

Acknowledgement and Receipt

I acknowledge that I have received a copy of Positive Steps ABA, LLC Notice of Privacy Practices. I further acknowledge that I have reviewed and understand the information presented in this notice, including the appropriate contact information for the party(ies) I should contact in the event that I have any further questions, concerns, requests, or complaints regarding any of the covered subject matter.

Client's Name: _____ DOB: _____

Parent/ Guardian Printed Name	Date

_____
Parent/Guardian Signature