Intake Packet

Thank you for selecting Spectrum of Hope to help meet the needs of your child. I am so excited to work with you!

The attached packet of information will inform you about policies and procedures and allow time to gather information prior to your intake appointment.

Thank you for trusting me to work with you and your family. I understand that forms can sometimes seem difficult or time-consuming, but this information will assist in providing the very best treatment to your child. If you need any assistance, please don't hesitate to contact me.

I look forward to meeting you and your child,

Casey Ayer, BCBA

(912)432-6748
caseyayer@spectrumofhopeaba.com

Steps to Begin ABA Services:

1. Complete and return the intake packet:

    - ▯ Intake Form
    - ▯ HIPPA Service Agreement and Consent Form
    - ▯ Patient Confidentiality Contact Form
    - ▯ Payment Policy Form
    - ▯ Request/Authorization to Release Confidential Medical & Mental Health Records and Information
    - ▯ Permission to Videotape and photograph (optional)
    - ▯ For Medicaid, A written prescription or letter from a psychologist or doctor stating that your child may benefit from ABA is required.
    - ▯ A copy of the most recent psychological evaluation is required.
    - ▯ A copy of the IEP (if your child has one) may be required.

2. If Insurance is involved, pre-approval is required prior to evaluation, therapy, or other service.

3. Intake Assessment with BCBA to evaluate, assess, interview, and complete any other necessary paperwork prior to writing the treatment plan

4. Meeting to review behavior plan.

5. Arrange regular schedule for ABA.

An overview of Spectrum of Hope's Approach to ABA Services

A typical ABA session:

- is completely positive
- focuses on skill acquisition and/or behavior reduction
- is individually designed to meet each child's unique needs
- focuses on motivation to learn
- uses the most-effective, evidence-based treatment approach

Individualized Behavior plans focus on:

- Remediating deficits related to diagnosis, including:
- increasing important, socially significant behaviors
- increasing communication skills including verbal behavior and social skills
- increasing play behaviors
- increasing self-help and adaptive skills
- increasing skills so that the child can interact with and function as same-age peers
- decreasing behaviors that impede the ability to learn

Spectrum of Hope is owned and operated by Casey Ayer, BCBA in which one-to-one services are provided directly by the BCBA. Treatment is closely monitored using data to make appropriate treatment decisions in collaboration with parents and/or caregivers.
Treatment plans are updated and submitted to insurance and care providers every 6 months.

In addition to the individual program, parent training programming is provided to address behaviors in- home and focuses on increasing skills and decreasing problem behaviors in all environments using state-of-the-art behavior interventions.

Behavioral assessment, parent training, program supervision, and quality monitoring are all part of each program and is supervised by the BCBA.

Financial Information

Currently, Spectrum of Hope accepts Tricare, Blue Cross Blue Shield, and Medicaid. Families are invoiced monthly for copays. Payment is due by the end of the month. Payments can be made in-person to BCBA or mailed to 57 Carson Street NE, Ludowici, Ga 31316. There is a $30 returned check fee for all checks returned by the bank.

Information Related to Scheduling and Sessions

Each case is led by Casey Ayer, BCBA. A Board-Certified Behavior Analyst operates at a master's degree level and is licensed by the Behavior Analyst Certification board. You can find out more about this credential at www.bacb.com.

Sessions for in-home therapy can range anywhere from 1-6 hours each day, depending on the unique needs of each client. Research is clear that consistent sessions result in better outcomes and makes scheduling more convenient for all parties. If this is not convenient, please let the BCBA know at your next appointment.

A parent or legal guardian is required to be present and available in the home throughout the therapy session(s).

Except in cases of emergency, 12-hour notice is required for all cancelled appointment. Payment for the appointment is required for all missed appointments not cancelled according to this policy. Insurance carriers are not responsible for missed appointment fees.

Families must give at least 2 week's notice on significant changes in their plans for in-home ABA session scheduling in order to facilitate consistency in service delivery.

The standard therapy hour consists of 45-50 minutes of direct contact with the client and 10-15 minutes devoted to required record-keeping and other administrative duties. It usually takes 10-15 minutes to arrange the materials and set up for sessions prior to engaging with the client. It also takes about 10-15 minutes at the end of the session to record data, take notes, tidy the setting, and discuss the session and/or answer questions with parents.

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This Notice of Private Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of PHI
Your PHI may be used and disclosed by your physician our office staff and others outside of our office that are involved in your care treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a home health agency that provides care with you. For example, your PHI may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for therapy services that may require that your relevant PHI be disclosed to obtain approval for the approved therapy services.

Healthcare Operation: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training or medical students, licensing and conducting or arranging for the other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: As required by law, Public Health Issues as required by law, Communicable Disease, Health oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity and National Security,

Workers Compensation, Inmates, Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164,500. Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke the authorization at any time in writing, except to the extent that your physician or the Physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request a restriction of your PHI: This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations.

You may also request that any part of your PHI not be disclosed to a family member or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices, your request must state the specific restriction requested and to whom you want the restriction to apply.

Consent and Release

I hereby consent to treatment by Spectrum of Hope, LLC, and authorize insurance benefits to be paid directly to Spectrum of Hope, LLC. I agree that I am responsible to pay 1) for services not covered by my insurance company, 2) co-payments and deductibles, and 3) any expense associated with the collection of a debt owed to them by me (i.e. Attorney fees, court cost or collection agency fee). I also consent to the release of pertinent medical information to my insurance carrier(s) for the purpose of processing health care claims.

HIPAA and Service Agreement:

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

Information Sharing and HIPPA

I give consent to Casey Ayer, as a BCBA for Spectrum of Hope, LLC.to discuss my child's progress and behaviors with any relevant school personnel, speech therapists, occupational therapists, etc. in order to provide the best possible care for my child.

X____

(signature of responsible party)

____

(date)

____

(witness)

Confidential Release Form

I, , do hereby authorize: Spectrum of Hope, LLC., including all employees, to RELEASE TO and OBTAIN FROM information from the record of ________________________________,

Date of birth: _______________________.

The information that may be released includes:

Physical Examination

Birth Record

Medical Examination

Psychological Examination

Psychosocial History

IEP/IFSP

Progress Notes

Summary of Treatment to Date

Discharge Summary

After Care Plan Medication

Education Record

I understand that I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose(s) specified above.
I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon), by written, dated, communication to the Office of Spectrum of Hope, LLC.

________________________________ ____________________________

Signature of Parent/Guardian Date

INTAKE QUESTIONNAIRE

Confidential

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information, which you think may be helpful in understanding your child. Spectrum of Hope will hold information provided by you as strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information.

Patient Information	
Child's Name: (first/last):	Parent/Guardian Name:
Phone Number:	DOB:
Street Address:	City/State/Zip:
Diagnosis:	Diagnosing Physician:
Date of Diagnosis:	Diagnosing Physician Contact #:
Primary Care Physician:	Primary Care Physician Contact #:
Insurance Information	
Subscriber's Name:	Birth date:
Subscriber's SSN:	Policy Number:
Employer:	Group Number:
Patient's relationship to subscriber:	**PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF CARD**
Background Information History	
Current Age:	Gender:
Mother's Name:	Father's Name:
Mom's Cell #:	Father's Cell #:
Email:	Email:
Siblings Names and Ages:	
Does he/she currently receive any other therapies (speech, OT, etc.)?	
If so, explain (provider/frequency of service):	

Medication		
Please list all current medications:		
Medication	Prescribed For	Dosage/Frequency

Spectrum of Hope
ABA Therapy

Educational Information	
Does your child attend school?	Does he/she have an IEP?
Name of School:	Grade:
Additional Information	
Please describe any behavior issues you are concerned about:	
Please describe your child's current communication skills:	
What else would you like us to know about your child?	
Please list 5 things that you would like your child to do more often:	
Please list 5 things that you would like your child to do less often:	

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 new 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 that we obtain your signature acknowledging that we have provided you with this information.

Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. 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 on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

SERVICES OFFERED

We will provide services specifically designed to help you (and/or your minor child), or otherwise provide you with referrals to other professionals. Our behavioral services consist primarily of individual assessments (behavioral evaluations), training, in-home and in-school consultations and observations, long- term ABA service provision to individuals diagnosed with autism spectrum disorder, and short-term consultations with individuals, parents, educators, and other related professionals.

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 necessitate 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 (see below) for appointments missed or cancelled with less than 12 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 under other conditions and as mandated by Georgia and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

TO PROTECT THE CLIENT OR OTHERS FROM HARM

If we have reason to suspect that a minor, elderly, or disabled person 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 to them. We will tell clients about these consultations. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

FEES

BCBA hourly fee is $142 per hour for consultations, meeting, and therapy. Assessments are typically $500- 700. Please call for travel rates for services provided more than 40 miles from 31316.

HEALTH CARE INSURANCE

If we file your insurance claims, you are responsible for copayments.

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. 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 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 that 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 that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make 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 sometimes when you will be available. Because of the nature of the services we provide, we do not provide on-- call coverage 24 hours per day, 7 days a week. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

CONSENT:

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required. I hereby voluntarily apply for and consent to services by Spectrum of Hope/Casey Ayer, BCBA. This consent applies to me, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent

____
Client or Child's name

______________________________	______________________________
Parent/Guardian #1 name	**Parent/Guardian #2 name**
______________________________	______________________________
Parent/Guardian #1 signature	**Parent/Guardian#2 signature**
______________________________	______________________________
Date	**Date**

Permission to Photograph (optional)

I give permission and consent for Spectrum of Hope 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.

Child's name:______________________________Date of birth: _________________________________

_______________________________ _______________________________

Print name (parent/guardian) Signature (parent/guardian) and date

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

_______________________________ _______________________________

Print name (parent/guardian) Signature/d a t e

Permission to Videotape
or Audiotape (optional)

I give permission and consent for Spectrum of Hope, 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 Behavior Matters, LLC and the family.

Child's name: _________________________________Date of birth: ____________________________________

_______________________________ _______________________________

Print name (parent/guardian) Signature (parent/guardian)/ Date

In addition to the above, I also give permission for Spectrum of Hope, LLC to use recorded video segments to present to parents and professionals for conferences and/or other training purposes.

_______________________________ _______________________________

Print name (parent/guardian) Signature (parent/guardian)/ Date

Parent Guidelines

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

1. Your child should be dressed and fed prior to arrival unless these skills are being addressed in the program.
2. A parent or responsible adult must be in the home when therapy is being provided.
3. The area being used for therapy must be a comfortable temperature and well lit.
4. The materials and reinforcers used for therapy should be left alone outside of therapy time.
5. The BCBA is NOT allowed to take a child in their automobile.
6. The BCBA must wait 15 minutes if child is not there at the therapy time and then is allowed to leave. The child will be considered absent and the session will not be rescheduled. ***You will be charged for the session and this is not billable to insurance.***
7. The telephone numbers of all therapists/BCBA should be in the front of the therapy book so that parents can contact them if necessary. Please do not call before 8 am and not after 6 pm.
8. Parents should contact the BCBA 24 hours prior to the appointment if the parent knows they are going to cancel a session. ***If more than 25% of sessions are cancelled in a 3-month period, your child may lose their therapy slot.***
9. **Sickness**. ***Please notify us, as soon as possible, (at least the night before the scheduled session n) if you know that your child will not be able to participate in the program the next day.***

   Sickness includes, but not limited to the following:

   - Temperature above 100
   - Communicable Disease
   - Chicken Pox
   - Hand/Foot/Mouth Disease
   - Rash
   - Vomit
   - Mumps
   - Chicken Pox
   - Strep Throat
   - Measles
   - Lice
   - Diarrhea
   - Pin worms

Parents are asked to use the same guidelines used in a school – if a child 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/BCBA arrives at the home and the child is sick, the therapist/BCBA will not be able to work with your child.

10. The therapist/BCBA will call the family if they are going to be arriving more than 10-15 minutes late.
11. If parents cancel a session, these hours are not made up unless the therapist/BCBA agrees to do so.
12. If a therapist/BCBA cancels a session, these hours may be made up as soon as possible and the family will be informed as to when this is going to occur.
13. The parents cannot change therapy hours because most of the therapists in your home will be servicing other children. If there is an occasional issue such as doctor's appointment or family occasion then every effort will be made to try to accommodate this. These accommodations must be made through the Supervisor.
14. BCBA cannot change appointment times without agreement with the family.
15. In the case of snow or inclement weather:

a) Please listen to the radio for announcements of school closing for the district in which you reside. If the district schools are closed it is an indication that driving in that area presents danger BCBA should not report to work that day.

b) Since schools in the district are closed on inclement weather days, the time missed on those days can be made up at the discretion of the BCBA and the family.

16. In case of an accident or unusual incident, the BCBA should complete a form and family and the Behavior Matters Executive director should be informed within 1 working day.
17. Parents and contractors should be respectful and courteous to each other. Open communication between parents and contractors is essential to the establishment of a successful program for the child. All communication must be done in a courteous and respectful manner. If there are any problems or concerns, please contact the Supervisor immediately.

18. Parents are encouraged to share with contractors any information that may be helpful in getting to know their child and will enable them to work successfully with the child.
19. Periodic videotaping of sessions may be helpful in assessing the progress of the child. Prior to a videotaping session, permission must be obtained by all parties involved and can be
terminated at any time. Additionally, parents may request a copy of the taped session on a medium provided by them.
20. No therapy for siblings. Spectrum providers are not obligated to work with siblings. If a BCBA feels a sibling can be used as a participant in a session, it is at their discretion.

I understand and agree to the parent guidelines.

____

Signature and date