Spectrum of Hope
ABA Therapy

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 us 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 us.

We look forward to meeting you and your child!

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Amy Mein, Office Manager and Intake Coordinator
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Website: www.spectrumofhopeaba.com

Steps to Begin ABA Services:

1. Complete and return the intake packet:
2. Each of these documents are required before your child can be assessed for ABA services:

   - Intake Forms and Agreement for ABA (All forms in this packet). Packet must be completed in its entirety.
   - Copy of insurance card(s).
   - A written prescription or letter from a psychologist or doctor stating that your child may benefit from ABA or an ABA referral is required.
   - A copy of the most recent psychological evaluation (diagnosing evaluation) is required.

3. If Insurance is involved, pre-approval is required prior to evaluation, therapy, or other service. This can sometimes take some time to get through.
4. Intake Assessment with BCBA to evaluate, assess, interview, and complete any other necessary paperwork prior to writing the treatment plan.
5. Meeting to review behavior plan.
6. Arrange regular schedule for ABA if your child qualifies for ABA services.
7. The initial assessment is designed to determine the need for therapy, if the services can be provided within the scope of our practice and if your child meets medically necessary guidelines set forth by insurance. Services are not guaranteed.
8. ABA is data-driven. If your child is not making progress, not attending consistently, or parent training requirements are not met, then you will be evaluated for discharge.

⇒ Please return this packet as soon as possible.

Additional documentation can be e-mailed to caseyayer@spectrumofhopeaba.com or sent by fax to 866-467-4321. This packet is automatically returned to me once it is completely filled out and signed.

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 and/or by Registered Behavior Technicians or Qualified Autism Service Practitioners that are overseen 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.

Failure to attend therapy session and/or parent training sessions will result in discharge.

Agreement for Applied Behavior Analysis Services

Applied Behavior Analysis (ABA) is a scientific discipline that utilizes behavioral principles to help individuals make meaningful and socially significant behavior changes. New skills and behavior are taught while any problematic behaviors are reduced/minimized. Spectrum of Hope uses Board Certified Behavior Analysts (BCBAs) to conduct functional behavior assessments, design behavior support plans, and train staff and family members on how to implement strategies. The goal of Spectrum's ABA program is to teach individuals how to access their environment more effectively, thereby reducing the need to engage in aberrant target behaviors. Spectrum's behavior support plans utilize positive reinforcement strategies, as well as a variety of other proactive measures to motivate individuals during ABA sessions and throughout the ABA program. On-going support, training, and consultation services are available to help service providers and family members maintain treatment gains.

ABA not only teaches skills but promotes maintenance and generalization of skills. Maintenance is used to determine whether or not the child can skill perform the skill after a given amount of time has passed. Generalization requires that the child not only learns a skill within a structured 1:1 environment, but ensures that the skill transfers to different people, materials, instructions, and environments. Individualized curricula are developed to facilitate learning and develop appropriate programming for each child. Areas that we word on include (but are not limited to):

- Language and functional communication: Communicating needs/wants to others
- Independent Play: Playing without assistance
- Social skills: Interacting with others
- Imitation: Imitating behaviors or vocalizations of others
- Gross/Fine Motor Skills: Control over balance and body movement
- Listener Responding: Attending and responding to spoken words
- Visual/Perceptual Skills: Interpreting things he/she sees visually
- Self-help skills: dressing, grooming, feeding toilet training, etc.

Parent/caregiver agrees to cooperate with Spectrum's efforts to provide services to the client (child) and family agrees to participate in the treatment process and follow through with interventions recommended by BCBA. Parent/caregiver acknowledges that BCBA shall have exclusive responsibility and authority to make all professional judgments and decisions with reference to the services rendered.

Parent/caregiver acknowledges that if their child is participating in a 1:1 treatment program with Spectrum, a minimum of monthly to biweekly supervision is required to properly supervise the program, to observe the child engaging in the program, and to implement changes to the program. This typically takes 1.5 to 2 hours and the RBTs on the child's team must also be in attendance.

ABA Program Overview

1. A functional behavior assessment (FBA) will be conducted by a BCBA and is a process for identifying the purpose or function of target behaviors. The BCBA gathers data, conducts interviews, and directly observes the individual's behaviors during the assessment period. A skills assessment is also completed to identify skill repertoire. Information gathered will be presented in the behavior support plan. The assessment process generally takes 4-6 weeks from the time the intake paperwork is turned in. If the BCBA is unable to establish initial contact within 2 weeks of the enrollment due to lack of response, then services will not move forward. If paperwork is not turned in with the intake (assessments, evaluations, referrals, etc.), then services will not move forward.
2. Information gathered from the FBA and skills assessment will be then used to design a behavior support plan. The plan will objectively define target and skill acquisition behaviors, describe the function of behaviors, identify treatment goals and objectives, and outline antecedent and consequence-based strategies. The behavior support plan will guide staff and parents on how to

interact with the individual in a way to occasion positive and appropriate behaviors, as well as how to respond in the event that target behaviors occur.

3. The BCBA will then present the plan to the parent/guardian and obtain consent to implement the plan. The BCBA will then train staff and family members on how to effectively implement all procedures outlined in the plan.
4. The BCBA and support staff will provide consultation services to ensure that the strategies are being implemented with consistency and to address any questions or concerns that come up during the treatment process. Treatment plans are updated every 6 months.
5. The BCBA will obtain data taken by support staff to review. The BCBA will analyze the data to evaluate effectiveness of the intervention and will make revisions, if necessary, to ensure progress toward treatment goals are being achieved.

Criteria for early discharge:

1. If BCBA or support staff have been unable to establish contact with parent/guardian due to lack of response within 2 weeks of intake packet being sent.
2. If required documentation is not received within 2 weeks of intake packet being sent.
3. If FBA identified environmental changes necessary for implementation of behavior support plan, services will not move forward until the recommended changes have been made. If environmental changes are not made within the initial period, discontinuation of ABA services will be recommended until the environmental changes have been met.
4. Environmental recommendations made by BCBA have not been met or caregiver is unwilling or unable to meet the recommendations.
5. Caregiver does not approve behavior support plan within 14 days.
6. Individual is not benefiting from services.
7. Individual, caregivers, or direct support staff are unwilling or unable to participate in the implementation of the behavior support plan.
8. Individual, caregivers, or direct support staff are at risk of or are being harmed by continued service.
9. There are repeat cancellations and/or client is not receiving appropriate recommended therapy hours due to unavailability.

Role of Spectrum of Hope:

1. Provide adequate staff to work with the individual.
2. Coordinate with BCBA to arrange staff training.
3. Provide supported to staff and caregivers regarding recommendation and implementation of behavior support plan.

Role of RBT/Support Staff and Caregivers:

1. Consistent participation in implementing behavior support plan and recommended strategies as written.
2. Collect applicable data to assist BCBA in monitoring progress.
3. Communicate with BCBA any identified issues with behavior support plan or implementation in order to find a resolution.

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. Clients without a current insurance authorization, who are paying privately for services, agree to pay for all services when services are rendered. 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.

If a current insurance authorization is on file, parent/caregiver authorizes Spectrum of Hope to file

insurance claims on their behalf. Parent also agrees to pay all co-payments, deductibles, and fees for co-insurance at the end of each week in which therapy is provided.

Even though Spectrum will verify eligibility and benefits, parents should be advised that a Statement of Benefits provided by an insurance carrier is never a guarantee of payment. In some cases, certain claims may be denied as "non-covered" services. In which case, parent/caregiver agrees to pay for all previously provided "non-covered" services. Parent/caregiver also acknowledges that Spectrum may temporarily suspend services until payment has been received.

In the event that there is a lapse in authorization, services may be temporarily suspended until authorization is approved to resume services.

FEES

BCBA hourly fee is $142 per hour for consultations, meeting, and therapy. Assessments are typically $500- 700. RBT hourly fee is $73/hour. Please call for travel rates for services provided more than 40 miles from 31316.

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. Registered Behavior Technicians (RBTs) are support staff that are overseen/supervised by BCBA. ABA Sessions must be completed in-clinic (located at 938 Elma G. Miles Parkway Hinesville, Ga 31313) at least once per week, unless other arrangements have been made with the BCBA. Parent training sessions will also be completed in-clinic.

A parent or legal guardian is required to be present and available in the home throughout the therapy session(s), unless ABA is provided at the clinic.

Sessions for in-home therapy can range anywhere from 2-8 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. Spectrum strongly recommends consistent attendance. Spectrum understands that emergencies and illnesses arise, which may cause a session to be cancelled. Spectrum reserves consult/therapy time for the child/client; therefore, except in cases of emergency, 12-hour notice is required for all cancelled appointments. A $30 cancellation fee is charged for all missed appointments not cancelled according to this policy. Insurance carriers are not responsible for missed appointment/cancellation fees. Repeat cancellations and/or the inability to carry out recommended treatment hours will result in discharge from the program.

Families must give at least 2 weeks' 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.

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 some times 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.

Termination Either Party may terminate this Agreement for any reason, including breach by either Party, or without reason, by providing ten (10) days written notice to the other Party.

Default Any of the following events or conditions shall be construed as a Default of this Agreement: (a) Client fails to pay any payment when due; or (b) Client indicates, through writing or otherwise, that Client has become insolvent, or otherwise incapable of making payment for SPECTRUM's services; or (c) the filing by or against Client of a petition under the Bankruptcy Code or any amendment thereto.

Remedies If any event of Default exists, SPECTRUM may, at any time, do one or more of the following in any order: (a) Require Client to pay to SPECTRUM on a date specified by SPECTRUM all acquired and unpaid payments for services rendered by SPECTRUM; (b) terminate this Agreement; (c) submit the dispute to mediation in accordance with this Agreement; and/or (d) file suit against Client to enforce Client's obligations that are due and owing pursuant to this Agreement. None of the above remedies are exclusive and SPECTRUM's exercise of one or more of the remedies listed above shall not preclude its exercise of any other remedy at any other time. No delay or failure on the part of SPECTRUM to enforce any right or remedy shall operate as a waiver or as acquiescence in any Default.

Attorneys' Fees In the event a Party is required to enforce any term of this Agreement, other than through the use of mediation services pursuant to this Agreement, the prevailing Party shall be entitled to recover attorneys' fees and costs incurred for pursuing or defending such action or claim.

Jurisdiction and Venue This Agreement, and rights and obligations of the Parties pursuant to the Agreement, shall be governed and construed in accordance with the laws of the State of Georgia. Any actions, claims or disputes regarding the subject matter of this Agreement or relating to the relationship between SPECTRUM and Client shall be brought in the appropriate court in Ludowici, Ga. For purposes of venue, this Agreement is deemed to have been executed in Ludowici, Ga.

WAIVER OF JURY TRIAL CLIENT AND SPECTRUM, BY SIGNING THIS AGREEMENT, MUTUALLY AND WILLINGLY WAIVE THE RIGHT TO A TRIAL BY JURY OF ALL CLAIMS MADE BETWEEN THE PARTIES, WHETHER NOW EXISTING OR LATER ARISING INCLUDING ALL CLAIMS, DEFENSES, COUNTERCLAIMS, CROSSCLAIMS, THIRD PARTY CLAIMS AND INTERVENOR'S CLAIMS, WHETHER ARISING FROM OR RELATED TO THE SERVICES PROVIDED BY SPECTRUM, THE PERFORMANCE OF THE DUTIES AND RESPONSIBILITIES OF THE PARTIES PURSUANT TO THIS AGREEMENT, OR WHETHER RELATED TO THE RELATIONSHIP BETWEEN THE PARTIES.

Dispute Resolution Should a dispute related to this Agreement arise between the Parties, the Parties shall make good faith efforts to resolve such dispute without filing an action or other claim with a court or other entity. If the Parties' good faith discussions should fail, the Parties agree to submit the dispute to mediation services. The Parties shall agree on an appropriate third party, who is non-biased and not related to the Parties in any way, in order to mediate the dispute between the Parties. The Parties agree to equally divide the costs of the mediation services amongst themselves. Only after the Parties exhaust the courses of action in this Section shall a Party be entitled to file an action or claim with a court of competent jurisdiction or some other type of entity.

CONFIDENTIAL INFORMATION

Confidentiality Except as may be required by law, during the term of this Agreement, plus five (5) years after the Agreement expires, is terminated, or otherwise concludes, Client shall maintain the confidentiality of all business policies, procedures, techniques, trade secrets other knowledge or processes developed by SPECTRUM. Client acknowledges that all program materials are prepared solely for Client's use and cannot be copied, disseminated, published, or shared with third parties without the approval of SPECTRUM. Client acknowledges that all program materials must be returned to SPECTRUM upon termination, expiration or conclusion of this Agreement.

Non-Disparagement Client shall not directly or indirectly, make any statement, whether in commercial or noncommercial speech, disparaging SPECTRUM or any affiliate of SPECTRUM, or any products or services offered by any of these.

Severability If any provision of this Agreement shall be deemed invalid, unenforceable or contrary to applicable law by a court of competent jurisdiction, the remaining provision(s) in whole or in part shall remain and survive if full force and effect.

Waiver of Consequential Damages Client acknowledges that there is a risk associated with any type of therapy or intervention and that therapy outcome is dependent upon several variables and success cannot be guaranteed. Therefore, Client hereby agrees that to the fullest extent permitted by law, SPECTRUM shall not be liable to Client (or to Client's child, family members, or any other individuals participating in SPECTRUM's services under this Agreement) for any special, indirect, incidental or consequential damages whatsoever, whether caused by SPECTRUM's own negligence, breach of contract, or other cause or causes including, but not limited to, loss of behavioral consulting services and the costs related to locating a new provider of such consulting services.

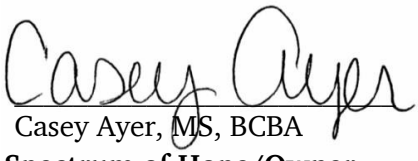
Limitation of Liability Client agrees that, to the extent a dispute, claim or other action arises between the Parties for injuries, losses, expenses or damages experienced by Client, Client's child, Client's family members or any other individuals participating in SPECTRUM's services under this Agreement, which relate to the services provided by SPECTRUM or any cause or causes including, but not limited to,

SPECTRUM's own negligence, acts, omissions, breach of contract or other liability, whether arising in contract, tort, strict liability or otherwise, SPECTRUM's liability, if any, for the loss or damage sustained shall be limited to $50,000 OR the total sum paid to SPECTRUM for its services by or on behalf of Client, whichever sum is greater.

Indemnification Client, and Client's respective successors and assigns, hereby jointly and severally indemnify and hold SPECTRUM, its affiliates and respective directors, officers, employees, consultants, attorneys and agents ("**Indemnified Parties**" or "**SPECTRUM**"), harmless from and against any and all liabilities, claims, actions or causes of action, assessments, losses, penalties, costs, losses, damages and expenses, including attorney's fees (including, without limitation, contingency or similar fee arrangements) and expert witness fees, sustained or incurred by SPECTRUM as a result of, or arising out of, or by virtue of: (a) the relationship between Client, Client's child and/or Client's family and SPECTRUM; (b) the services provided by SPECTRUM to Client, Client's child and/or Client's family; (c) the inaccuracy of any representation made by the Client to SPECTRUM herein; (d) **SPECTRUM's own negligence or misconduct**; or (e) any and all liabilities arising out of any claim made by any person, organization or association against SPECTRUM with respect to the services contemplated by this Agreement, except for claims based on the gross negligence or willful misconduct of SPECTRUM. SPECTRUM may defend any such claim or cause of action brought or asserted against SPECTRUM arising out of any of the foregoing set forth in subsections (a)-(e) of this section at the expense of Client, with counsel designated by SPECTRUM, and to the exclusion of Client. Alternatively, SPECTRUM may call upon the Client to defend any such action at Client's sole cost and expense. SPECTRUM may, in its

sole and exclusive discretion, adjust, settle, or compromise any such claim or cause of action made upon or brought against SPECTRUM, and Client shall indemnify SPECTRUM for any such amounts adjusted, settled or compromised, as well as all costs and expenses, including attorneys' fees (including, without limitation, contingency or similar fee arrangements) incurred in connection therewith. Client acknowledges and agrees that Client's liability and obligations hereunder are unconditional, unlimited and shall continue in full force and effect at all times hereafter, including, without limitation, unless specifically terminated in writing by SPECTRUM.

Therefore, the Parties agree to the terms of this Agreement as set forth above executed on date indicated below.

_____	_____
Individual/Guardian	Date
	
_____	_____
Casey Ayer, MS, BCBA	Date
Spectrum of Hope/Owner	

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.

CONFIDENTIAL INFORMATION

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.

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.

CONFIDENTIAL INFORMATION

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.

X_____
(signature of responsible party)

_____
(date)

_____
(witness)

Confidential Release Form

I, (parent name)_____, do hereby authorize: Spectrum of Hope, LLC., including all employees, to RELEASE TO and OBTAIN FROM information from the record of (child's name)_____,

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 Record
- ☐ 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. Fax# 866-467-4321. Office #: 912-294-4055.

_____ _____

Signature of Parent/Guardian Date

CONFIDENTIAL INFORMATION

INTAKE QUESTIONNAIRE

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(s) and Birth date(s):
Social Security #:	
Date of Birth:	
Street Address:	
Primary Diagnosis:	Diagnosing Physician:
Date of Diagnosis:	Diagnosing Physician Contact #:
Primary Care Physician:	Primary Care Physician Contact #:
Primary Insurance Information	
Insurance Company Name:	
Policy Holder's Name:	Member ID:
Policy Holder's SSN:	Policy Number:
Employer:	Group Number:
Patient's relationship to policy holder:	**PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF CARD**
Secondary Insurance Information	
Insurance Company Name:	
Policy Holder's Name:	Member ID:
Policy Holder's SSN:	Policy Number:
Employer:	Group Number:
Patient's relationship to policy holder:	**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:	
Please explain any other therapies the child receives (speech, OT, etc.) including frequency and intensity of services:	
Medication	
Please list all current medications include dosage (write "none" if child isn't on any medications):	

CONFIDENTIAL INFORMATION

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:	
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:	
What is your availability for ABA therapy? Any other information?:	

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. Staff are NOT allowed to take a child in their automobile.
6. Staff must wait 15 minutes after the scheduled therapy time. If the child is not present or asleep, then the child will be considered absent and the session will not be rescheduled. ***You will be charged the $30 cancellation fee, and this is not billable to insurance. The fee will be collected at the next scheduled session.***
7. Please do not call staff before 8 am and not after 6 pm.
8. Parents should contact the BCBA 12 hours prior to the appointment if the parent knows they are going to cancel a session. ***Repeat cancellations will lead to discharge.***
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 staff arrives at the home and the child is sick, the RBT/BCBA will not be able to work with your child.

10. Staff 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 RBT/BCBA agrees to do so.

12. If an RBT/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 staff 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/BCBA.

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 and staff 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, staff should complete a form and family and Casey Ayer, BCBA should be informed within 1 working day.

17. Parents and staff should be respectful and courteous to each other. Open communication between parents and staff 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 staff 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.

21. Should staff feel unsafe or personal family matters interfere with therapy sessions, then the staff member will leave the session and contact the BCBA for further guidance.

I understand and agree to the parent guidelines.

_____ _____

Signature Date

Consent for ABA Services

Your signature below indicates that you have received and read the information in this document and agree to Spectrum of Hope's program policies, procedures, and service delivery methods.

I give my consent for ABA services to be implemented by Spectrum of Hope:

_____ _____

Signature Date

_____ _____

Signature Date

Spectrum of Hope

Telepractice Services Client Consent

Client Name: _____ Date: _____

Telepractice Services are the use of video conferencing software in lieu of or in addition to face-to-face sessions with a client for one or more Behavioral Health Services.
Times when Telepractice Services may be utilized:

- Behavior Analyst Services
- Parent Training
- Family and/or team meetings
- Staff Supervision

Provision of Telepractice Services

• Telepractice will not replace Registered Behavior Technician (RBT) Services.
• Telepractice will be used in conjunction with face-to-face services and supervision services.
• Your SPECTRUM clinician or local service office may be consulted at any time regarding questions, comments, or concerns.
• Telepractice will not be used for any type of emergency situation and 9-1-1 will always be called.

CLIENT/LEGALLY RESPONSIBLE PERSON

As the: (1) parent or legal guardian of a minor (under 18 years of age); (2) client receiving services if I am my own guardian and it has been determined that I can give consent; or (3) guardian/legally responsible person I acknowledge that I have been advised of the proper utilization of Telepractice Services and have received a copy of this consent. By signing below, I acknowledge that I have had an opportunity to fully discuss the Telepractice Services with my SPECTRUM Clinician and all questions have been answered to my satisfaction. I hereby give consent for Telepractice Services.

• I or SPECTRUM may withdraw this consent at any time verbally and/or by written notification via electronic or handwritten communication to the office. SPECTRUM will, within a reasonable period of time, offer an alternative
service, if one is available. * If an alternative service is refused, or no alternative is available, SPECTRUM will provide assistance in referring/transitioning the client to another provider if available.

Consenting to Telepractice services is a condition for this client to receive care.

• SPECTRUM will provide, maintain and retain ownership of the equipment. The equipment should only be used for SPECTRUM Telepractice Services.
• Any recording of a Telepractice service must first be approved via written consent prior to recording and/or use of recording. Telepractice Services are transmitted as per HIPAA compliant software.

• If for any reason an equipment or internet malfunction occurs, a make-up session will be scheduled within an appropriate time frame according to service authorization.

_____	_____	_____
Client/Legal Guardian	Date	Witness