



LUMNOVA HEALTH

INTAKE FORMS

THANK YOU

for expressing interest in our company, LumNova Behavioral Health. Our dedicated team of professional therapists are trained to implement a variety of effective clinical interventions. This multifaceted and cross-modal approach allows us to meet children where they are and create plans that work for kids and their families. Our goal is to provide your child with not just excellent care but the best care. Working collaboratively, we can empower people with Autism Spectrum Disorder and produce results that transform lives.

404.576.8644
hello@lumnova.health
www.lumnova.health

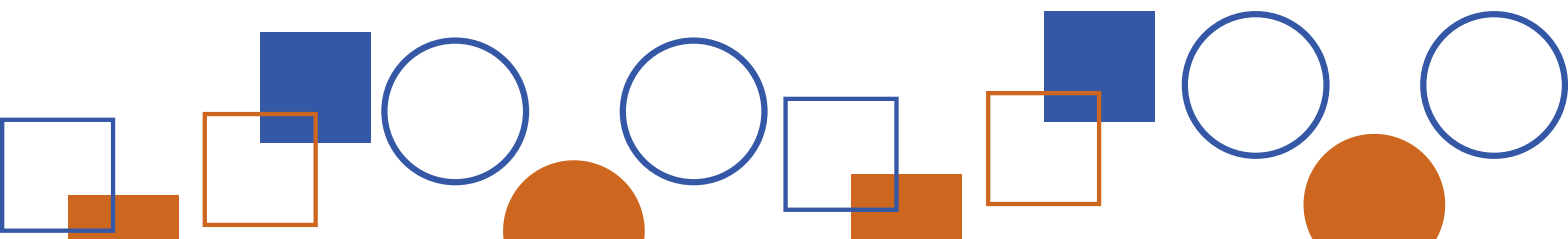
In this document you will find the following forms to sign:

1. Consent to Evaluate
2. Financial Responsibility/Insurance Disclaimer
3. HIPAA Regulations
4. Waiver of HIPAA Liability
5. Privacy/Authorization for Treatment/Release of Information/Reimbursement
6. Recurring Payment Authorization Form
7. Release of Digital Imaging/Recording
8. Waiver and Permission Regarding Injury

Please send a copy of the following:

1. Copy of front and back of Insurance Card.
2. Copy of Diagnosis (if and where applicable).
3. Referral for ABA Services.

If you have any questions you can email us at hello@lumnova.health or call us at 404.576.8644 and one of our staff will follow up within 24 hours. Thank you again, we look forward to working with you!





LUMNOVA HEALTH

INFORMED CONSENT TO EVALUATE

Client Name: _____

Client Date of Birth: _____

Client Address: _____

Parent/Legal Guardian Name: _____

Relationship to Client: _____

I, parent or legal guardian of _____ hereby grants permission for _____ (BCBA) of LumNova Behavioral Health to conduct an evaluation to assess my child's development.

Parent/Guardian Signature: _____

Date: _____



FINANCIAL RESPONSIBILITY / INSURANCE DISCLAIMER FORM

LumNova Behavioral Health will do our utmost to obtain full coverage for all therapy and related services by billing your child's private health insurance plan. It is our pleasure to provide you with this service as a part of our goal to offer all-inclusive services for your child and make things easier for our clients.

I hereby authorize LumNova Behavioral Health to bill my insurance company and receive direct payment from my primary insurance company, as well as an secondary insurance companies, so that LumNova Behavioral Health will be compensated for therapy services rendered.

Furthermore, I understand that I am financially responsible for any unpaid fees and for services and materials not covered by my insurance providers. I also acknowledge that I am responsible for all co-pays, co-insurance and deductibles that are included are part of my insurance contracts. I understand that I am fully responsible should my policy lapse or max-out of coverage.

It is my responsibility to inquire and understand my insurance policy(s); and to communicate in writing with LumNova Behavioral Health when coverage changes occur.

By signing this form I understand and agree that regardless of insurance status, I am ultimately responsible for the balance of my account for any therapy services rendered; and that this balance is due and payable upon the completion of services, unless prior arrangements have been made.

By signing this form, I give LumNova Behavioral Health the rights to bill my insurance company and use this form as my "signature of file".

Client Name: _____

Parent / Legal Guardian Signature: _____

Relationship to Client: _____

Date: _____

Signature: _____ Date: _____

HIPAA FORM

Notice of Privacy Practices

As Required by The Privacy Regulations Created as a Result of the Health Insurance Portability And Accountability Act (1996)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU/YOUR CHILD (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI)

PLEASE REVIEW THIS NOTICE CAREFULLY

OUR COMMITMENT TO YOUR PRIVACY

This practice is dedicated to maintaining the privacy of your IIHI. In conducting our business, we will create records regarding the patient and the services we provide to the patient. We are required by law to maintain the confidentiality of health information that identifies the patient. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we have in effect at this time. We realize that the laws are complicated, but we must provide you with the following information:

- How we may use and disclose the patient's IIHI
- The patient's privacy rights are stipulated by the IIHI
- Our obligations concerning the use and disclosure of IIHI

The terms of this notice apply to all records containing IIHI that are created and maintained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision to this notice will be effective for all of the patient's records that our practice has created or maintained in the past and for any records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times. You may request a copy of our most current notice at any time.

1. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, CONTACT OUR OFFICE AT 404.576.8644. WE MAY USE AND DISCLOSE YOUR IIHI IN THE FOLLOWING WAYS.

The following categories describe the different ways in which we may use and disclose your IIHI without obtaining your consent

- **Treatment** - Our practice may use your IIHI to treat you/your child. People who work for the practice may use/disclose your IIHI in order to treat the patient or assist other in the patient's treatment. Additionally, we may disclose the IIHI to others who may assist in the patient's care, such as a spouse or parents. This practice will share information with primary care providers (PCP) and other health personnel.
- **Payment** - Our practice may use and disclose IIHI in order to bill and collect payment for the services and products the patient may receive from us. For example, we may contact your health insurer with details regarding the patient's treatment from third parties that may be reasonable for such costs, such as family member. Also we may use your IIHI to bill you directly for services and items.

2. USE AND DISCLOSURE OF IIHI UNDER CERTAIN CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose IIHI

- **Lawsuits and Similar Proceedings** - Our practice may use and disclose IIHI in response to a court of administrative order, if the patient is involved in a lawsuit or similar proceeding. We also may disclose IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we made an effort to inform you of the request and/or procedure to obtain an order protecting the information the party has requested.

- **Law Enforcement** - We may release a patient's IIHI if asked to do so by law enforcement officials.
- **Research** - Our practice may use and disclose IIHI for research purpose in certain limited circumstances. We will obtain your written authorization to use for IIHI purposes.
- **Worker's Compensation** - Our practice may release IIHI for worker's compensation and similar programs.

3.THE PATIENT'S RIGHTS REGARDING IIHI

You have following rights regarding the IIHI that we maintain about your/your child

- **Confidential Communication** - You have the right to request that our practice communicate with you regarding your child's health and related issues in a particular manner or at a certain location. In order to request a type of confidential communication, you must make a written request to this practice. Our practice will accommodate reasonable requests. You do not need to give a reason for your request. We currently use the phone, cell phone, fax, and e-mail to communicate with designated other parties. Please advise the staff in writing if you do not your information to be shared in this manner.
- **Requesting Restrictions** - You have the right to request a restriction in our use or disclosure of IIHI for treatment, payment, or other health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your child's care or the payments of said care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat the patient. In order to request a restriction of our use or disclosure of IIHI, you must make your request in writing to this practice. Your request must describe in a clear and concise fashion:
 - The information you wish restricted;
 - Whether you are requesting a limit to our practice's use, disclosure, or both;
 - To whom you want the limit to apply.
- **Inspection and Copies** - You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about the patient, including medical and billing records, but not including psychotherapy notes. You must submit your request in writing to this practice. Our practice may deny your request to inspect and/or copy in limited circumstances; however, you may request a review of our denial.
- **Amendment** - You may ask us to amend the patient's health information if you believe it to be incorrect or incomplete and you may request an amendment for as long as the information is kept by our practice. To request an amendment, your request must be made, in writing and submitted to this practice. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the reason supporting it, in writing.
- **Right to a paper copy of this Notice** - You are entitled to receive a paper copy of this notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice visit our website, www.LumNova.Health.
- **Right to file a complaint** - If you believe that patient privacy have been violated, you may file a complaint with our practice or with the Department of Health and Human Services. You will not be penalized for filing a complaint.
- **Right to provide an authorization for other uses and disclosures** - Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorizations you provide to us regarding the use and reasons described in the authorization. Please not that we are required to retain records of your care.

All inquiries or written requests should be submitted to:

*LumNova Behavioral Health
1083 Forest Heights Road
Stone Mountain, GA 30093*

I hereby acknowledge that I have received a copy of HIPAA Notification.

Client Name: _____

Parent/Legal Guardian Signature_____

Relationship to Client: _____

Date:_____



WAIVER OF HIPAA LIABILITY

Due to federal guidelines protecting all private patient health information, LumNova Behavioral Health has a policy that prohibits discussion of all information regarding your child's assessment, treatment, and care, in public areas such as the patient waiting room or in the open clinic environment. All discussion regarding your child will take place in a private room away from the public.

By signing this waiver of HIPAA liability, you as the parent or guardian, are releasing LumNova Behavioral Health from any harm or fault caused by discussing the private health information in such open access areas in our facility such as the waiting room or gym area, with you as the parent or a preferred guardian you send to accompany your child to their therapy sessions.

This waiver is encourage ongoing discussion between the therapist and family. This waiver will be in place from the date signed below, until such a time that you as the parent an/or guardian request in writing to LumNova Behavioral Health that all discussions take place in a private setting.

Client Name:_____

Parent/Guardian Signature:_____

Relationship to Client:_____

Date:_____

PRIVACY AND AUTHORIZATION

Privacy:

_____ Please initial that you have received a copy of the HIPAA Privacy Regulations

Authorization for Treatment:

_____ Please initial that you authorize LumNova Behavioral Health to render all therapies to the patient

Release of Information:

- This authorization or copy of same, permits the release to LumNova, of any medical educational, or other information necessary for treatment and/or to process claim information for services rendered by LumNova Behavioral Health.
- This authorization, or copy of same, permits LumNova Behavioral Health to disclose any information in connection with the patient's treatment to any physician, therapist, educational authority, government agency (including Medicaid), insurance company and/or other health care facilities/professionals requesting information either verbally or in writing.

___ Patient / Parents / Legal Guardians (entered in Central Reach)

___ Primary Care Physician (entered in Central Reach)

___ Other: _____

___ Other: _____

Reimbursement Coverage

- The patient hereby assigns LumNova Behavioral Health all medical insurance benefits (both primary and secondary) and any other benefits to which the patient may be entitled for any therapy services rendered by LumNova Behavioral Health.
- The patient authorizes and directs LumNova Behavioral Health to apply and file for all such benefits on behalf of the patient.
- The patient is responsible for obtaining all authorization information for therapy services.
- The patient agrees that they shall be responsible for any charges that are not covered by the insurance provider.

Parent / Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____



LUMNOVA HEALTH

RELEASE OF DIGITAL IMAGING/RECORDING

I, parent or legal guardian of _____ hereby grant LumNova Behavioral Health to photograph and/or record my child; for release for use in research, to illustrate progression of their skills, or at the therapist's discretion.

This consent does not extend to the promotional use of photographs or videos. Other confirmation will be pursued for photographs or videos that will be used for that purpose.

Client Name: _____

Parent / Legal Guardian Signature: _____

Relationship to Client: _____

Date: _____



WAIVER

As the parent of legal guardian of _____ I hereby waive, discharge, and agree to hold harmless LumNova Behavioral Health, its agents, officers, consultants, employees, and volunteers from all liability to me, my spouse, or my child for any and all loss and personal injury, including injury resulting in death; unless the damage and personal injury has been caused by the sole negligence of the agents, officers, employees, or volunteers of LumNova Behavioral Health. I acknowledge that this waiver applies to the total duration of time my child is in the care of LumNova Behavioral Health; both on grounds and off grounds.

I understand that accidents can occur. If first aid is required prior to the arrival of emergency personnel, LumNova staff may provide it. I also consent to emergency medical treatment, hospitalization, or other medical treatment as may be necessary for the welfare of my child by a physician, qualified nurse and/or hospital, in the event of injury or illness during all periods of time in which my child is away from their legal residence as a member of LumNova Behavioral Health. I hereby waive any liability on behalf of spouse, the above-named child and myself, of LumNova Behavioral Health and of its agents, consultants, employees, or volunteers arising out of such medical treatment.

_____ ***Please Initial: Waiver and Permission Regarding Injury***

Client Name: _____

Parent / Legal Guardian Signature: _____

Relationship to Client: _____

Date: _____