

Happy Kids Autism Intervention Services
703 W FM 2410
Harker Heights, TX 76548
Phone: 254-716-8743
Fax: 254-227-6027
www.happykidsautism.com



ABA Program Intake Packet

Thank you for selecting Happy Kids Autism Intervention Services to meet the needs of your child and family. Our mission is to provide you with highly individualized quality services utilizing the science and principles of Applied Behavior Analysis. We know this is a very important decision in your family and child's life and we will work diligently to meet your needs.

Attached you will find several forms as well as policies and procedures. Please allow yourself time to gather the necessary information and thoroughly read all parts of the packet. This information gathering process may seem lengthy but it is necessary for us to properly assist you and your family. If at any time you have questions or need assistance in this process please feel free to contact us.

We look forward to embarking on a journey of partnership with you and your family and we would like you to know that we dedicate ourselves to the effective treatment of our clients and families as a whole, recognizing that successful programs include individualized behavioral therapy, extensive parent training, and on-going community support.

Thank you,
Patricia S. "Suzee" Stewart, M.Ed., BCBA
suzee_stewart@happykidsautism.com

Happy Kids
Autism Intervention Services

CLIENT INTAKE QUESTIONNAIRE

*******CONFIDENTIAL*******

The following questionnaire is to be completed by the client's parent or legal guardian. Please feel free to add any additional information which you think may be helpful in understanding your child. All information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines. Please use the backs of pages for any additional information.

PLEASE PRINT

Name of Person Completing Form: _____

Legal Name of Client: _____ Nickname: _____

Date of Birth: _____ Age: _____

Home Address: _____

Home Telephone Number: _____ Cell Phone Number: _____

School Name: _____ Grade: _____ Teacher: _____

Please list your child's current educational setting and include the number of hours per week your child attends school: _____

Special Education Services: Yes NO If, yes please attach a copy of most current IEP

Biographical Information

Parent/Guardian #1: _____ Relationship to Child: _____

Address: _____ Home Phone: _____

_____ Work or Cell Phone: _____

Occupation: _____ Employer: _____

Parent/Guardian #2: _____ Relationship to Child: _____

Address: _____ Home Phone: _____

Work or Cell Phone: _____

Occupation: _____ Employer: _____

Marital Status: Married Remarried Divorced Separated Widowed Single Cohabitants

- If divorced, who has physical custody? _____ Is it full or joint? _____
- Who has legal custody? _____ Is it full or joint? _____
- If divorced, please provide a copy of the custody agreement.

Number of Adults in Household: _____

Names: _____	Relationships: _____	Age: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Number of Children in Household: _____

Names: _____	Relationships: _____	Age: _____
_____	_____	_____
_____	_____	_____

Military Family: YES NO If yes, please list service branch, rank, etc. _____

Are you requesting services under the Comprehensive Autism Care Demonstration (CACD)? __ yes __ no

If yes, please provide the sponsor's name, social security number and name of case manager.

Has the family experienced any recent deployments or is a deployment expected in the near future?

Medical Information

What is/are your child's current diagnosis(es):

****Please provide a copy of evaluation report if available****

Date of Evaluation and Name of Diagnosing Provider: _____

Please list symptoms or concerns present during initial diagnostic evaluation (i.e. non-verbal, repeating words and/or phrases over and over, lining up items, playing with toys in non-typical fashion, lack of eye contact, doesn't like loud noises or changes in routine, etc.): _____

Is there a family history of an autism spectrum disorder or related diagnosis? YES NO (please circle)

If yes, please list family member and diagnosis: _____

Please provide name and contact information including fax number of your child’s current primary care physician or referring medical provider:

Is your child currently taking any medications? YES NO If yes, please list below.

Medication	Date Prescribed	Dosage	Administration Times	Used For

Has your child ever been admitted to a hospital/treatment center psychiatric, medical, behavioral or crisis situations:

History of Applied Behavior Analysis (ABA) Therapy and other Services

Is your child currently receiving ABA Therapy? YES NO (please circle)

If yes, please list name of ABA provider and number of hours attended per week:

Has your child previously attended ABA Therapy? YES NO (please circle)

If yes, please list name(s) of ABA provider(s) and number of hours attended per week:

Other Services (i.e. Speech, Occupational Therapy, Physical Therapy, etc.):

Is your child currently receiving any additional services? YES NO (please circle)

If yes, please list name(s) of provider(s) and type of service provided:

Has your child previously received other services? YES NO (please circle)

If yes, please list name(s) of provider(s) and type of service provided:

Current Concerns

Please describe the current problems your child is having, and what type of services you are seeking from us for these problems. Please use the back of this page for additional space.

Describe your child's eating habits:

Describe your child's sleeping habits:

Please give a brief overview of your child's daily schedule. Include weekend routines.

Reinforcement/Child Preferences

Describe the items and activities that your child enjoys:

Identify typical reinforcers in these groups:

Food items: _____

Toys: _____

Praise: _____

Physical Activities: _____

Describe what your child would do if left alone to their own devices for a period of time:

Does your child complete tasks for the pleasure of completing the task and being recognized for having finished the task? _____

Expectations

Describe the skill areas that are a priority for your child (e.g. language, socialization, problem behaviors):

Describe your short term and long term goals for your child:

Short term (1-2 years): _____

Long Term (3-5 years): _____

FINANCIAL CONTRACT

Financially Responsible Party:

Name: _____ SSN#: _____
Address: P.O. Box _____ / _____
State: _____ Zip _____ Phone Number: _____
Relationship to patient/student: _____
Employer: _____ Work Number: _____

INSURANCE INFORMATION: (Please furnish insurance card)

Insurance Co: _____ Phone: _____
Member ID: _____ Group Number: _____
Name of Insured: _____ SSN# _____
Address of Insured: _____
Relationship to patient/student: _____
If Tricare: Active Retired Prime Standard Reserve Select

SECONDARY HEALTH INSURANCE INFORMATION: (Please furnish insurance card)

Insurance Co: _____ Phone: _____
Member ID: _____ Group Number: _____
Name of Insured: _____ SSN# _____
Address of Insured: _____
Relationship to patient/student: _____
If Tricare: Active Retired Prime Standard Reserve Select

Note: Tricare is always a secondary insurance to all other commercial insurance plans. All claims will need to be submitted through the primary insurance first to avoid any claim denials. Failure to submit through the primary insurance will result in non-payment of claims and financially responsible party will be held liable for all charges due to failure to disclose other health insurance.

_____ (Initial) **I have read and understand the statement above regarding primary and secondary insurance plans. I agree that I have disclosed all applicable insurance plans. I also further understand that I will be held financially responsible for any claim refiling fees, claim denials or recoupment of claim payments due to failure to failure to disclose additional insurance.**

Payment

Client's portion of payment is due at the time services are rendered unless a previous arrangement has been made. There may be a balance due (co-payments/co-insurance/cost share) after the Explanation of Benefits is received (when we file for insurance). Invoices will be issued on a monthly basis and payment is expected within 15 days. Private pay without insurance is due at the time of service. Happy Kids Autism Intervention Services at its sole discretion and on an individual basis may create payment plans for balances on account.

Payments accepted include cash, check, electronic payments and most major credit cards. Returned checks will incur a **\$35.00** service fee.

In the matter of divorced parents, payment is still due at the time of treatment, regardless of the terms outlined in a divorce decree. Any missed balance will be the responsibility of the parent who signed this financial contract, which would include inappropriate cancellations or missed sessions.

Fees

Traditional one on one ABA Therapy

BCBA Hourly Fee \$137.50

BCaBA Hourly Fee \$100.00

Consultation including in-home consultations, phone consultations, supervision of tutors, meetings, training
Hourly Fee\$ 137.50

ABA Therapist

Registered Behavior Technician Hourly Fee \$ 80.00

Individual Evaluations-

Behavioral Language Assessment (ABLLS-R or VB-MAPP)

Flat Fee \$2000.00

Functional Behavior Assessment/Analysis

Flat Fee \$ 2000.00

****\$150 discount offered if scheduled at the same time

This flat fee typically includes a review of records that you provide us, an initial one-hour interview with the referral source, the evaluation, comprehensive written report, limited consultations with other professionals you may be working with and one follow-up feedback session. Additional services such as any other consultative or therapeutic sessions, follow-up consultations with you or other parties (teachers, physicians, or other allied professionals), school observations, or preparation of any additional reports will be charged the appropriate hourly rate.

___ Clients with Insurance Benefits

Your policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, we will check benefits for you, and inform you of what we have learned, but this is not a guarantee of coverage. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered medically necessary under your individual policy. If your insurance company says you may have coverage, we will provide necessary information to the insurance carrier to obtain pre-authorization for evaluation/treatment and approval for continued therapy. We check benefits for you, but this is not a guarantee of coverage. We will provide a detailed invoice for you to file with your insurance or we may file as a convenience with some insurance companies. This is your acknowledgement that you will be financially responsible for any non-covered services as outlined in this Financial Agreement.

___ Clients Who Do Not have Benefits Under Their Policy

We have checked your benefits and have been informed by your insurance company that some or all of the services you need are not covered under your policy. This is either due to policy exclusions or not meeting your policy's definition of **Medical Necessity**. This is your acknowledgement that you will be financially responsible for these non-covered services as outlined in this Financial Agreement.

___ Private Pay

The billing form is designed to furnish necessary information for insurance companies. Attach the billing form to your insurance claim as you would other medical receipts for submission. We will send the insurance company any requested additional records that they require to process your claims. Your insurance policy is a

contract between you and your insurance company. We are not a party to that contract. It is your responsibility to collect reimbursement from your insurance company.

If therapy expenses are not covered by your insurance policy or if you are private pay, keep the billing statements to possibly submit with income taxes as a medical deduction.

I have read, understand, and agree to the above financial policy for payments of professional fees and cancellation fees.

Signature

Date

ASSIGNMENT OF BENEFITS AND CONSENT TO TREAT

Applied behavior analysis is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior (Baer, Wolf & Risley, 1968; Sulzer-Azaroff & Mayer, 1991).

Our approach to working with each client is completely positive and focuses on building skills. You or your child's program will be tailored to meet you and your child's unique needs. All strategies are supported by the most current research.

You and/or your child have the right to treatment by a competent behavior analyst. While it may be relatively simple to understand the principles of ABA, it is not possible to implement ethical, effective programs without significant practice and supervised experience.

Following initial behavioral assessments (behavioral language assessments and/or functional behavior assessment) you or your child's program will be designed to address the specific issues discovered during the evaluations and may include issues common in autism and identified by the National Academy of Sciences as essential such as:

- Understanding and using language
- Building broader social skills
- Communicating with and relating to peers
- Building age appropriate and symbolic play skills
- Increasing conceptual thing and cognitive skills
- Behavioral intervention procedures

You will be provided with regular formal progress reviews on goals and objectives and on-going updates with regard to behavioral assessments.

Our trained therapists work one-on-one with each child closely monitoring emotional responses in order to match the difficulty of the material and method of instruction to the child's ability and rate of learning. All therapists have extensive training specifically in research supported treatments for autism spectrum disorders.

All therapists are board certified by the Behavior Analysis Certification Board or are supervised by a Board Certified Behavior Analyst. All therapists will adhere to the *Guidelines for Responsible Conduct* of the Behavior Analyst Certification Board®. A copy of these Guidelines is available upon request.

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 and behavioral language assessments), traditional one to one ABA therapy, training, in-home and in-school consultation and observations, supervision of in-home programs/therapists and social skills training groups.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

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 mandates by Texas 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 client is being abused, we are required to report this (and any additional information on request) to the appropriate state agency.

PROFESSIONAL CONSULTATIONS

Behavior Analysts routinely consult with other professionals on specific cases. In doing so, we make every effort to avoid revealing identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them. Unless you object, we do not typically tell clients about these consultations; however, these consultations will be noted in your private information. If you want us to talk with or release 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.

PROFESSIONAL RECORDS

Pursuant to HIPAA, Protected Health Information includes information about reasons for seeking professional services; the impact of any current or ongoing problems or concerns; assessment; consultative, or therapeutic goals; progress towards those goals, medical or developmental history, social history, treatment history, records received from other professionals, billing records, releases, and any reports sent to other including statements for your insurance carrier. You have the right to request in writing a copy of your records. Copying charges and postage fees will apply.

CONTACTING US

You may contact us at the phone number or email address provided at the end of this packet. If we are unavailable, we will make every effort to return your call or respond to your email promptly (within 24-48 hours with the exception of holidays and weekends). If you are difficult to reach, please leave dates/times when you will be available.

INFORMED CONSENT

Your signature(s) below indicate that you have read the information in this document and agree to abide by its terms, and that you have received the HIPAA notice form described above.

I agree to have my child evaluated/treated through Happy Kids Autism Intervention Services. 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.

_____ Initial

I also understand that Happy Kids Autism Intervention Services specializes in the evaluation and treatment of problem behaviors, and that if Happy Kids Autism Intervention Services is unable to meet my particular needs, I will be referred to an appropriate agency or individual.

_____ Initial

I understand and agree that I am responsible for the payment of all charges regardless of insurance coverage or other plans available to me. Additionally, I understand and agree to pay any and all collections costs and /or attorney's fees if any delinquent balance is placed with an agency or attorney for collection, suit, or legal action. I also acknowledge that confidentiality is waived in matters involving collections and the sharing of information sufficient to pursue recovery of debts owed.

_____ Initial

I authorize the release of any medical or other information necessary to process a claim. I also request payment of any benefits for services rendered by Happy Kids Autism Intervention Services to be made directly to Happy Kids Autism Intervention Services. I also agree to remit any insurance payments made directly to me for

services rendered at Happy Kids Autism Intervention Services, unless I have already paid the balance due for service dates included on payment

_____ Initial

By virtue of my signature, I authorize Happy Kids Autism Intervention Services and any of its employees or other authorized personnel to provide therapy services to the client. Concerns or complaints about services may be directed to Patricia S. “Suzee” Stewart, M.Ed., BCBA @ 254-716-8743 or email suzee_stewart@happykidsautism.com.

Client’s Name

Date

Parent or Guardian’s Name/Signature

Date

Parent or Guardian’s Name/Signature

Date

ATTENDANCE CONTRACT

In order to maximize the benefits of therapy, it is very important all scheduled appointments be attended. The consistency of attending therapy sessions assures your child will obtain maximum treatment benefit, and assist in meeting your goals. A missed or late appointment disrupts therapy schedules which impact your child, Happy Kids as well as other patients.

In signing this form, you are indicating you understand the attendance policy and the consequences of not keeping your appointments. We anticipate you will adhere to the following:

I understand Happy Kids' financial policy states any cancellation must ONLY be in the case of a true illness (fever, vomiting, diarrhea, requires doctor's visit, etc...) or a family emergency in order to not be penalized. I understand any appointment missed for any other reason will be considered an absence. ONE sick day will be allotted per month unless adequate medical documentation is provided deeming therapy attendance is not permitted. I agree to notify Happy Kids to cancel my appointments with at least 24-hour notice; if not I will be charged \$50 per hour of scheduled treatment (i.e.- a missed 2-hour appointment would require a \$100 payment). This fee is not billable to the insurance company and the sole responsibility of the beneficiary's family. Family emergencies will be taken into consideration. Please schedule all general wellness appointments outside of therapy times. I understand that if my regular therapist is not available, my child will be seen by another therapist or supervisor if one is available. Notice will be provided to the family by Happy Kids of this situation when possible.

ATTENDANCE POLICY PROBATION

If I am in violation of the Happy Kids attendance policy I will be contacted by a program supervisor and notified of probationary status. During the 2-week probationary period in order for services to proceed as scheduled the following requirements must be met:

1. Maintain an attendance record of 80%
2. Adhere to ALL attendance policy guidelines
3. Agree to the financial stipulations below

If a cancellation is made during the probationary period without 24-hour notice a \$50 per hour of treatment fee MUST be collected PRIOR to onset of the next scheduled therapy session. If at any time during the 2-week probationary period, the requirements set forth are violated; Happy Kids reserves the right to place services on hold. After successful completion of the 2-week probationary period it is expected for the attendance policy to be adhered to. If placed on attendance probation MORE than once a year a \$100 refundable deposit may be required to continue services.

NO-SHOWS

I understand that two "no-shows", within a 6-month period, are grounds for discharge from therapy. "No shows" will result in a fee of \$50 per hour of scheduled treatment due PRIOR to the next scheduled appointment. **I understand that my physician or primary service coordinator as well as case manager will be notified of my failure to show for appointments resulting in discharge from therapy.**

SAME DAY CANCELLATIONS

I understand that two or more same day cancellations within a 6-month period will result in probationary status. Same day cancellations will result in a fee of \$50 per hour of scheduled treatment due PRIOR to the next scheduled appointment.

VACATIONS

I agree to notify Happy Kids, with written notice, 30 days in advance of any vacations or extended leaves of absence which will cause TWO or more missed appointments. This notice will ensure Happy Kids is able to plan accordingly. Family vacations will be approved once per calendar year. Vacations and extended leaves of absences will REQUIRE prior approval by the Executive Director.

LATE ARRIVALS AND LATE PICK-UP

I understand that if I arrive more than 15 minutes late, therapy may not be provided that day, depending on what was planned for that session (i.e. procedures that require a full hour to complete). Two times tardy (more than 10 minutes) for therapy equals an absence.

While my child is attending therapy, I may leave during their session(s) but WILL be able to be reached at the number Happy Kids has on file in case of an emergency. I agree to return 10 minutes PRIOR to the end of session(s). If I am more than 15 minutes late picking up my child I understand may be charged for the extra time (\$25.00) due at the next appointment having to wait. This fee WILL be collected, in full, at the next date of service prior to the onset of the next scheduled therapy session.

“Happy Kid’s” mission is to ensure measurable progress and facilitate every client’s success. However, time availability is a valuable commodity and if your child is discharged from our practice for attendance reasons your family will be placed back on the waitlist for an upcoming timeslot which may or may not be with the same therapists, therapy days and time.

Following these guidelines will greatly facilitate quality of treatment. Thank you for your cooperation and acknowledgement of the significance of consistent therapy attendance.

I have read this information regarding the importance of therapy attendance and understand that I will be charged for late cancellations as stipulated in the financial policy. Any questions regarding this attendance contract please contact the Executive Director, Suzee Stewart at suzee_stewart@happykidsautism.com or (254)716-8743

Signature: _____

Date: _____

Effective date: March 1, 2015

Notice Of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A CLIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

Understanding Your Health Record/ Information

When you receive therapy services from Happy Kids Autism Intervention Services, we will obtain health and personal information from you and create a record. This record will include information about the treatment/services that you receive from Happy Kids Autism Intervention Services, your current or ongoing problems or concerns; assessment; consultative, or therapeutic goals; progress towards those goals, medical or developmental history, social history, treatment history, records received from other professionals, and the payment for the services received.

Your Privacy Rights

You can request to look at or get a copy of the health information we have about you. Protected Health (PHI) Information includes information about reasons for seeking professional services; the impact of any current or ongoing problems or concerns; assessment; consultative, or therapeutic goals; progress towards those goals, medical or developmental history, social history, treatment history, records received from other professionals, billing records, releases, and any reports sent to other including statements for your insurance carrier. You have the right to request in writing a copy of your records. Copying charges and postage fees will apply.

You can ask to correct information if you think it is wrong. We will not destroy or change your records, but will add the correct information and make a note in your records that the information has been changed. You will be notified if we are not able to correct your information as requested.

You can ask for a list of who we have given your health information to over the last six years. The list will include disclosures that are not routine or explained in this notice.

You can ask us to limit some of the ways we use or share your health information. The law does not require us to agree to it. If we agree, we will put the agreement in writing and follow it, except in case of an emergency or when required by law.

You can ask us to contact you at a different place or in some other way. We will agree if your request is reasonable.

You have the right to take back your written permission for Happy Kids Autism Intervention Services to disclose your health information. You will be unable to take back your permission if your information was already disclosed based on your written permission.

You can get a copy of this notice any time that you ask for it.

You must provide us with a written request for the above privacy rights, except for requests to obtain a paper copy of this notice. Requests should be mailed to Happy Kids Autism Intervention Services, 1103 Smith Lane, Bruceville, TX 76630.

Our Duties

We are required by law to protect the privacy of your health information. We will not use or let other people see your health information without your permission, except in the ways we tell you in this notice.

We will ask you for your written permission (authorization) to use or disclose your health information. There are times when we are allowed to use or disclose your health information without your permission, as explained in this notice.

We are required by law to give you this notice of our legal duties and privacy practices. We are required to follow the terms of this notice. We will ask you to sign an acknowledgement that you received this notice. We can change the contents of this notice. If we do, we will provide you with written notice of these changes.

Our employees must protect the privacy of your health information as part of their jobs. We do not let our employees see your health information unless they need it as part of their jobs.

Treatment, Payment and Health Care Operations

We may use or disclose your health information to provide services to you, to obtain payment for those services, or for our own health care operations.

Treatment

We may share health information about you to provide, coordinate, or manage your therapy/services. This includes providing direct therapy to you, consulting with other professionals within the field and or referring you to another agency.

Payment

We can use or disclose health information to arrange for payment for providing services to you, such as filing insurance claims. Example: Information about you and the services we provided is included in the bills we submit to your health insurance plan so they can confirm that services were provided. If necessary, we may seek assistance from an outside party in order to collect payment for services rendered to you. In such cases, any disclosures are limited to the minimum that is necessary to achieve the purpose.

Health Care Operations

We can also use your health information for health care operations such as program reviews, auditing functions, business planning, and reviewing performance of professionals. Example: Our quality assurance staff reviews records to be sure we are delivering appropriate treatment of high quality.

To report suspected child abuse or neglect to a government authority.

To a government authority if we think that you are a victim of abuse. We may disclose your health information to a person legally authorized to investigate a report that you have been abused or denied your rights.

To your legally authorized representative (LAR). We may share your health information with a person appointed by a court to represent your interests.

In judicial and administrative proceedings, we may disclose your health information if a court or administrative judge has issued an order or subpoena that requires us to disclose it. .

For further Information or if you have any questions you may contact us at 254-716-8743.

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments? YES NO

May we leave a message on your voicemail either at home or on cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If yes, please list the members allowed:

This consent was signed by: _____ (printed name)

Signature: _____ Date: _____

Witness: _____ Date: _____

HAPPY KIDS PHOTO AND VIDEO RELEASE FORM

We would love to have your permission to use pictures and possibly videos of your kiddo(s) for our Facebook page, Web-site, educational resources, etc... Please fill out the form below indicating whether we may or may not use pictures and/or videos of your child. This form will be valid for 1 year and the option to make changes is always available. If you have any questions, please feel free to contact us. Have a great day ☺

Thanks for your help,
Happy Kids Team

Child Name: _____

I give Happy Kids Autism Intervention Services permission to use pictures and/or videos of my child on their Web-site and/or Facebook page.

Please circle Yes or No under Pictures and Videos

Pictures
(YES or NO)

Videos
(YES or NO)

Parent Name: _____

Parent Signature: _____

Date: _____