Medical/Treatment/Behavior Information

Primary Care and Diagnostician:	Primary Care Physician: Physician Address: Email: Phone:
Medications:	Is your child on medication? If yes, please list type, administration times, usage: TYPE: ADMINISTRATION: USED FOR:
History:	Are there any drug of food Allergies/any adverse reactions to medications treatments? If yes, please list below: Has the child ever been admitted to a hospital/ treatment center for psychiatric, behavioral, or crisis situations? If yes, explain below: Are there any medical conditions that need to be considered when delivering ABA treatment? If yes, please explain below: Family history: Provide any relevant medical health family history information:
Treatment history:	What other services is your child currently receiving both in school and out of school (complete chart below). Please email, fax or mail a copy of the child's most recent IEP or IFSP THERAPY- HOME THERAPY -SCHOOL What past therapies or treatments have you done for/with your child? Please explain below (Ex ABA, Speech, Occupational):

Behavior History:	What, if any, behavior issues does your child have? Ex., self-injurious, aggressive towards others, etc., please explain. Include methods used to decrease these behaviors. Please describe any suicidal risks or risks to harm others, if applicable:
Psychosocial History:	Psychosocial History (For children and adolescents: include pre-natal and post-natal events and developmental history. For teenagers and older: include history of sexual behavior and/or use of cigarettes, alcohol or other substances, if applicable):
Physical & Social Emotional Developmental History:	Is physical development a concern, if so how? Is there a communication concern? Describe the problem Does your child have social emotional developmental concerns? Are you concerned about your child's interaction and behavior? Please provide any details here: Are you concerned about your child's thinking,

	memory,

	problem-solving, or curiosity? Are you concerned about feeding, sleeping, or sensory/regulatory?
Community Resources:	What resources did you use in the past or are you currently utilizing: support groups, social services, school-based services, other supports?
Communication History:	What current communication skills does your child have or lack? What resources are currently used to help with communication: Ex., sign language, PECS, verbal, please explain below

Goals and Commitment

Goals:	What are your immediate goals for your child? Please explain below:
Commitment:	What level of commitment are you willing to make at home in order for your child to achieve the goals above? Do you understand the risks of non-compliance with treatment recommendations? What spiritual or cultural variables might affect or impact treatment? Are there any relevant legal issues for your family?

☐ ☐

Goals and Commitment

Signature:	I hereby acknowledge that the information contained in this application is accurate in all respects. Parent/Guardian Name: (PRINT): Signature of Parent/Guardian:_____Date:_____

Consent and Release

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

(signature of responsible party)

(witness)

Date:

Services and Diagnosis

Diagnosis	Primary Diagnosis: Diagnosing Physician: Date of Diagnosis: Physician Phone:_____ Physician fax:_____ Does your child have a diagnosis for Autism within the past three years? If yes, please attach Do you have a letter of Medical necessity or referral for ABA? If yes, attach
Secondary Diagnosis	Secondary Diganois: Doctor assigning diagnosis
Specialists	Other service providers/specialists your child is seeing (type): If yes, can we collaborate with the other service provider? Yes _____ No __

Previous and current services	What other therapy has your child received in the past and how did he/she respond What other therapy is your child currently receiving and how is he/she responding:

School	School your child attends: Does your child have an IEP: Yes No
Developmental History	Please describe child's milestones in developments:
	Crawling and walking and running:
	Talking:
	Other:

Diagnosis	Primary Diagnosis: Diagnosing Physician: Date of Diagnosis: Physician Phone:_____ Physician fax:_____ Does your child have a diagnosis for Autism within the past three years? If yes, please attach Do you have a letter of Medical necessity or referral for ABA? If yes, attach Please attach insurance card front and back:

Coordination of care
#1

CONFIDENTIAL OBTAIN/RELEASE FORM for Physician or Other Provider

Patient Release of Behavioral/Medical Information

I,_____, do hereby authorize ABA SUCCESS, including all employees, to RELEASE TO and OBTAIN FROM information from the record of:

(Print Child/Client Name) (Date of Birth)

TO: _____
(Print Physician or other Provider's name that we are authorized to release information to)

_____ Street
Address City State Zip

_____
Phone of Physician Fax Email

The information that may be obtained/released includes the following, unless otherwise noted:
* Physical examination * Birth Record * Progress Notes * Medical examination * Summary of treatment to date
* Psychological exam * Psychosocial examination * IEP/IFSP * Discharge summary * After care plan * Medication record * Education record

OR_____Check here if you DECLINE to have Coordination of Care Information released.

_____
Signature Date

Coordination of care
#2

CONFIDENTIAL OBTAIN/RELEASE FORM for Related Services/School

Patient Release of Behavioral/Medical Information

I, , do hereby authorize ABA SUCCESS, including all employees, to RELEASE TO and OBTAIN FROM information from the record of:

_____

(Print Child/Client Name) (Date of Birth)

TO: _____
(Specify School or Related Services Provider Agency)

_____ Street
Address City State Zip

_____
Phone of Physician Fax Email

The information that may be obtained/released includes the following, unless otherwise noted:
* Physical examination * Birth Record * Progress Notes * Medical examination * Summary of treatment to date
* Psychological exam * Psychosocial examination * IEP/IFSP * Discharge summary * After care plan * Medication record * Education record

OR_____Check here if you DECLINE to have Coordination of Care Information released.

_____
Signature Date

Authorization to Process and Appeal Claims

I,_____, do hereby authorize ABA SUCCESS, including all employees, to RELEASE TO and OBTAIN FROM

information from the record of:

_____ (Print Child/Client Name) (Date of Birth)

ABA Success, including all employees, to process and appeal claims for services they render for:

_____ (Print Child/Client Name) (Date of Birth)

through my/his/her insurance:

_____ (Insurance Policy Name and ID #)

I also authorize ABA Success to communicate with:

(Insurance

Company)

regarding all medical and financial information contained in my insurance file. I understand this information is confidential and will only be released as specified in this authorization.

_____

Signature of Parent/Guardian **Date**

Assignment of Benefits

I,_____, do hereby assign all healthcare benefits, to include major medical benefits to which I/my child

(Print Child/Client Name) (Date of Birth)

am entitled. I hereby authorize and direct my insurance carrier to issue payment check(s) directly to ABA Success for self and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

_____

Signature Date

Informed Consent to Treatment and Assessments

- I will be given a clear description from my/my child's behavioral health provider regarding the problems, diagnosis, personal strengths/limitations and treatment interventions proposed.
- I will be given a clear recommendation for the types of treatment recommended, such as Applied Behavioral Analysis (ABA) or parent training. Times, dates, and session length will be discussed with my behavioral health provider.
- I voluntarily agree to undergo behavioral health treatment and understand that I may end treatment at any time for me/my child. I understand that my behavioral health provider may want to discuss this with me/my child, but that I reserve the right to stop treatment at any time. Furthermore, I understand that my/my child's behavioral health provider may make diagnostic and treatment recommendations with which I do not agree (e.g. modality of treatment, duration of treatment, frequency of visits, etc.).
- I understand that my/my child's behavioral health provider cannot guarantee results of behavioral health services. However, there will be clearly stated reasons, goals, and objectives for continuing/discontinuing behavioral health treatment. I understand the risks of noncompliance with treatment. This will be discussed with my/my child's behavioral health provider.
- I understand that if I have a grievance with my/my child's behavioral health provider, I will first attempt to communicate this directly to him/her. In the event that the grievance is not satisfactorily resolved, I understand how to complete a "Feedback Form".
- I understand that this "Informed Consent/Limits of Confidentiality Form" is not intended to be "all inclusive" of aspects

of my/my child's behavioral health treatment. It is only intended to provide some useful information before deciding to engage in behavioral health treatment.

Limits of Confidentiality

A. The information that you/your child shares with your Behavioral Health Provider is considered to be confidential. In most cases, information cannot be released to another party without your written consent. However, in certain circumstances, information can be shared legally without your permission. These circumstances include:

1. Suicide: if you/your child are assessed to be a danger to yourself; cannot guarantee your physical safety against the intention of suicide; and/or have immediate suicidal plans, this information is not considered to be "confidential". Actions may be taken to ensure your safety.
2. Homicide: if you are assessed to be a danger to others; cannot guarantee their safety; and have immediate, specific plans to cause fatal injury/harm to another person, this information is not considered to be "confidential". Actions may be taken to protect the safety of others. The police may be notified of your intentions as well as the intended victim.
3. Court order/subpoena: Your Behavioral Health Provider(s) can be required to relinquish a copy of your written Behavioral Health Record to the appropriate Courts. Behavioral Health Providers can also be subpoenaed to testify in court without your consent.
4. Child abuse/neglect: Georgia Law requires your Behavioral Health Provider to report to the appropriate authorities (i.e. Child Protective Services) any suspicion or evidence of child abuse or neglect. This law also applies to past incidents of abuse or neglect.
5. Elder abuse/neglect: Georgia Law requires your Behavioral Health Provider to report to the appropriate authorities any suspicion or evidence of elder abuse/neglect.
6. Laws regarding minors in behavioral health services: certain information may be shared with parent/legal guardians at the discretion of the behavioral health provider(s).

B. Behavioral Health confidential information may also be used in a number of ways within ABA Success without your written permission for coordinating services and delivering quality care. You may be informed if this is the case. These may include:

a. Consultations and case conference with other providers at ABA success.
b. In supervisory meetings with student interns at ABA success.
c. With providers in other services here at ABA success.
d. For billing purposes: a diagnosis is given to your insurer for reimbursement purposes

EXECUTION: I have reviewed this "Informed Consent to Treatment/Limits of Confidentiality" information with my behavioral health provider.____(please initial)
I have been given the opportunity to ask questions about this information. A copy of this information is available upon request._(please initial)

_____

Signature of Parent/Guardian Date

_____

Signature of Behavior Health Provider Date

Notice to Parents Regarding Confidentiality

NOTICE TO PARENTS/GUARDIANS/PATIENTS REGARDING CONFIDENTIALITY POLICIES OF ABA SUCCESS APPLIED BEHAVIORAL ANALYSIS (ABA) PROGRAM AND PARENTS' RIGHTS REGARDING ACCESS TO AND AMENDMENT OF THEIR CHILD'S RECORDS.

Confidentiality

All ABA success policies and procedures regarding confidentiality and parent access to records are required to be in compliance with the regulations of the Department of Public Health under the regulations of the State of Georgia. A child's clinical record is considered an educational, not medical, record and is governed by the Federal Family Educational Rights and Privacy Act (FERPA). Insurance billing/claiming records must also meet the requirements of the Federal Health Insurance Portability and Accountability Act (HIPAA). Service Providers who are licensed, registered, or certified under NYS Education Law must retain their records in accordance with the laws and regulations that apply to their profession. Policies and procedures for confidentiality apply throughout the stages of collection, storage, disclosure and destruction of records, including electronic records. All providers delivering services are required to develop a policy/procedure describing how they will maintain compliance with the confidentiality requirements.

Written parent consent must be obtained before personally identifiable information is disclosed to anyone other than authorized individuals. If the purpose is for any other reason, (e.g. record review for quality assurance by individuals not directly involved in the child/family's participation in the ABA Program), the parent must be informed of the names of the individuals that request access and the purpose for the access, and provide written consent for such access. If consent is given, those individuals must also be informed about, and required to adhere to, the confidentiality policies and procedures of the program and must adhere to all legal requirements that protect ABA records containing sensitive information. The Georgia Department of Public Health, as the lead agency responsible for oversight of the records, is required to monitor providers of the program's evaluation, services, and service coordination. The department is authorized to perform on-site reviews of ABA providers under contract with municipalities. FERPA authorizes the disclosure of the child/family's record, without parent consent, to specified officials e.g., (state officials/IPRO) for audit or evaluation purposes of any federally or state-supported education program or in connection with the enforcement of or compliance with federal legal requirements which relate to any such program.

Access To and Amending Records Parents have a right to review their child's records or to have them reviewed by a representative on their behalf unless such access is prohibited under State or Federal law. Parents also have a right to an explanation and interpretation of material included in any record upon request and a copy of any record within 10 working days of the request (if the request is made as part of mediation or an impartial hearing, a copy must be provided within 5 days.) In order to review their child's record, a parent will be requested to make such request, in writing, (if parent is unable to write the request, a phone call will suffice) to the program director who will make an appointment for the Document Ref: 3WCE3-PUWAC-DN4XQ-6JMAK Page 14 of 20 Notice to Parents Regarding Confidentiality parent or their representative to come to the office to review the file. The program director will arrange a place where the parent may review the file. A fee not to exceed 10 cents per page for the first copy and 25 cents per page for additional copies may be charged to the parent to copy records, unless the fee prevents the parent from inspecting and reviewing the record. No fee may be charged for records related to evaluations and assessments or for the search and retrieval of records.

The parent has a right to request an amendment to their child's record when the parent believes the information contained in the record is inaccurate, misleading, or violates the privacy of any other rights of their child. In order to amend the child's record when the parent believes that there is information in the record that violates the privacy or any other rights for their child, they will be instructed to put their request in writing to the Director of the ABA program. The Director will reach a decision regarding whether or not the record may be amended by reviewing the request and all the pertinent records and

by interviewing the appropriate staff. If the information in their record is found to be inaccurate, misleading, or to violate the privacy of the child/family, the provider will amend the information and will inform the family's service coordinator. The service coordinator will notify the parent in writing of the amendment. If the provider decides not to amend the record as requested, they must inform the service coordinator of this decision. The service coordinator is responsible for
informing the parent in writing of the provider's decision not to amend the record and that the parent has the

right to a hearing. The hearing will be conducted by an individual designated by the municipality, who does not have a direct interest in the outcome of the hearing.

Quality Assurance Record Review ABA Success routinely reviews files to ensure that we are providing the highest standards of practice. All staff are informed about and required to adhere to all confidentiality requirements applicable to personally identifiable information within the program.

Policy on Emails Staff and contracted providers are instructed that emails cannot contain child-specific identifiable information. Staff and contracted providers are informed that the use of ID numbers is acceptable. Child specific identifiable information includes a list of personal characteristics or other information that would make it possible to identify the child, the parent or other family members with reasonable certainty. In addition to obvious identifiers such as name, address, etc., the combination of facts presented in the email (e.g. initials, family composition, unique diagnosis, heritage, neighborhood, etc.) should not be able to identify a particular family or child. In the event that a parent requests personnel to use e-mail that is not encrypted for communication of personally identifiable information, the parent must sign a specific written consent. When email is used there is a danger of breach of confidentiality and the parent must lists the parties who will be involved in email communication, and identified what information will be shared via email.

Parent/Guardian Acknowledgement of Confidentiality Policy My parental rights regarding confidentiality of and access to my child's record as practiced by ABA success ABA program has been explained to me by my service coordinator or service provider.

_____ _____

Signature **Date**

Patient Name (Printed):_____

Disclaimer Concerning COVID 19

Parent/Guardian Name: Child/Patient Name:

Covid 19 Disclaimer: By accepting services in person, I voluntarily assume any and all risks related to potential COVID-19 exposure. I hereby agree to hold the agency harmless if the provider(s), student, student's family, and/or any other parties associated therein, contract Covid 19 during the course of the services provided.

_____

Parent/Guardian Signature

Relief for Autism Authorization form

By signing this Authorization, I hereby direct the use or disclosure to Relief for Autism of certain information pertaining to me and/or my dependent's health or health care as set forth below. This Authorization concerns the following medical information about me and/or my dependent: All records pertaining to the diagnosis of autism spectrum disorder and/or other diagnosis requiring other therapies.This authorization automatically

expires five years after the date hereof.

The purpose(s) of this use or disclosure is (list all purposes):

1. To assist me in obtaining insurance coverage and appropriate services for my or my dependent's diagnosis.
2. I am aware and agree that Relief for Autism may file appeals on my behalf and/or on behalf of my dependent.
3. I am aware and agree that Relief for Autism may file complaints to any authorities and/or official bodies on my behalf and/or on behalf of my dependent.
4. I am aware that any appeals and/or complaints filed on my behalf and/or on behalf of my dependent may be filed as part of an all-inclusive appeal and/or complaint on behalf of a number of individuals and/or on behalf of a number of practice groups.

I understand that at any time I have the right to revoke this Authorization pursuant to Relief for Autism's Notice of Privacy Practices, except to the extent that Relief for Autism has already acted in reliance on the Authorization.

I understand that I may revoke this Authorization by contacting Relief for Autism. I understand that it is possible that information used or disclosed pursuant to this Authorization may be redisclosed by the recipient and may no longer be subject to privacy protections provided by law.

[Please note that some insurance carriers require you to fill out their own Release of Information (in addition to Relief for Autism requiring you to fill out this form.) If that is the case, you will be supplied with the form from your insurance carrier to fill out and sign as well.]

Please sign below to indicate that you have read this Authorization and agree with its terms.

_____

Signature of Individual or Individual's Representative **Date**

_____

Print Individual's Name

I,_____(Print Representative's Name), am signing this Authorization on behalf of the Individual set forth above. My authority to sign this Authorization is as follows:

Relationship to Individual: _____

ABA SUCCESS

By signing this Authorization, I hereby direct the use or disclosure to Autism Cares Network of certain information pertaining to me and/or my dependent's health or health care as set forth below.

This Authorization concerns the following medical information about me and/or my dependent:
All records pertaining to the diagnosis of autism spectrum disorder and/or other diagnosis requiring other therapies.

This authorization automatically expires five years after the date hereof.

The purpose(s) of this use or disclosure is (list all purposes):

1. To assist me in obtaining insurance coverage and appropriate services for my or my dependent's diagnosis.
2. I am aware and agree that Autism Cares Network may file appeals on my behalf and/or on behalf of my dependent.
3. I am aware and agree that Autism Cares Network may file complaints to any authorities and/or official bodies on my behalf and/or on behalf of my dependent.
4. I am aware that any appeals and/or complaints filed on my behalf and/or on behalf of my dependent may be filed as part of an all-inclusive appeal and/or complaint on behalf of a number of individuals and/or on behalf of a number of practice groups.

I understand that at any time I have the right to revoke this Authorization pursuant to for Autism Cares Network's Notice of Privacy Practices, except to the extent that Autism Cares Network has already acted in reliance on the Authorization. I understand that I may revoke this Authorization by contacting Autism. Cares Network. I understand that it is possible that information used or disclosed pursuant to this Authorization may be redisclosed by the recipient and may no longer be subject to privacy protections provided by law.

Please note that some insurance carriers require you to fill out their own Release of Information (in addition to Autism Cares Network requiring you to fill out this form.) If that is the case, you will be supplied with the form from your insurance carrier to fill out and sign as well.

Please sign below to indicate that you have read this Authorization and agree with its terms

Signature of Individual or Representative Date

Print Individual's Name Relationship to Child

I,_____(Print Representative's Name) am signing this Authorization on behalf of the Individual set forth above.

Street Address:_____City:_____

State:_____Zip:_____

Email:_____

Home Phone:_____Cell Phone:_____

Additional information if needed: Internal use only