Client Information:

Name: _____

Date of Birth: _____**Gender:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Parent/Guardian: _____

Phone Number: _____

SCHEDULE AVAILABILITY

Please list all times your child is available for therapy between the hours of 8:00 and 7pm M-F:

Please also indicate your preference for frequency of visits by each provider:

Behavior Technician: _____ **per week** **Supervisor:** _____ **per month**

Top 3 session times/days/ location

1._____ **2.** _____ **3.** _____

Service Agreement and Consent Form

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operation. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

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

If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

FEES

BCBA and BCaBA hourly fee is $125 per hour for consultations, meeting, and therapy. Assessments are typically between 5-10 hours. Our hourly fee for Behavior Technician is $60 an hour. Please call for travel rates for services provided more than 30 miles from 99577.

Financial Information

We are always open to learning about your coverage or changes in practices and policies of insurers. We are currently accepting payment for services through the Star and mini grant offered from Stone Soup Group, many insurances, and private pay.

It is our policy to invoice families for cost-share monthly. Payment is due by the 15th of the month. Payments should be mailed to 16941 North Eagle River Loop Road, Eagle River, AK 99577. There is a $40 Returned Check fee for all checks returned by the bank. _____**Initial**

If we file your insurance claims, you are responsible for co-payment and additional fees not covered by insurance. By initialing, you are acknowledging that you understand this condition of service and commit to promptly paying Behavior Matters for the services we provide to you. We accept cash, personal checks and money orders, and pay pal. If your healthcare insurance payer does not cover ABA therapy services, you are required to make self-pay arrangements for the usual and customary pricing of our services (see self-pay rates below). _____**Initial**

CONTACTING US

Given there 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. 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.

Cancellation Policy

We appreciate the opportunity of being of service to you. Our office is dedicated to excellence in patient care. Please take a moment to read and become familiar with this policy. Should you have any questions, the office

staff is happy to help. By presenting this policy in advance, we can avoid any surprises or misunderstandings. We appreciate your time and your understanding.

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please discuss schedule changes at the end of your appointment with your therapist and the front desk administrator. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24-48 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday morning appointments our office appreciates being notified no later than Friday by 12 pm noon. This will allow other patients in need of care to be accommodated as we have a waiting list. It is both unfair to the other patients and therapists to not allow for others to schedule in the open time slots.

- If a session is more than 10 minutes delayed due to late arrival of the client, the parent(s)/guardian will be charged a $10.00 late fee. ****Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian.*** _____ **initial**

- If a parent(s)/guardian is more than 5 minutes late to pick their child up, the parent(s)/guardian will be charged $1 for every minute they are late. You will be charged $6 on the 6th minute of being late. This is to ensure that parents are present, so the therapist can collaborate with the parent(s)/guardian and other children's sessions start on time. ****Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian.*** _____ **initial**

- If a therapy session cancelled within 24 hours of the appointment time or is missed without any notice (this is counted as a no-show - except in cases of emergency), will result in a cancellation or no-show fee of $50, unless you have a Doctor's note. ****Note: Insurance companies DO NOT reimburse for no show fees; this is the responsibility of the parent(s)/guardian.*** _____ **initial**

- We request that families give us at least two weeks notice on significant changes in their plans for ABA therapy sessions scheduling in order to facilitate consistency in service delivery. _____**initial**

- Two consecutive no-shows require your child to be placed on an on-hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, your child will lose his/her therapy time and be placed on a waiting list. ____ **initial**

- We require an 80% attendance rate (per quarter) and will need to take the patient off the therapist's schedule if it is not adhered to. *Note: We will be tracking visit numbers and as a courtesy, we will notify you when your percentage drops below the required 80%.* _____ **initial**

- The universal standard for therapy, be it the insurance standards or the professional standards of various organizations like the APA, ASHA, etc., is that a therapy: "hour" is 45-50 minutes of direct contact with the patient with the remaining 10-15 minutes devoted to required record keeping and other administrative requirements. Typically, for a 3-hour in-home therapy session, our staff take ~10 minutes to arrange the materials prior to commencing direct therapy with the child and ~ 15 minutes at the end to record data, tidy the setting, and discuss the session with the parent. _____**Initial**

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, such as an extended trip, we will hold your therapy spot for up to three weeks. We will then have to place you on the waiting list and will fit you back in the schedule as soon as we can. **I hereby understand the above cancellation policy and agree to abide by it.**

- Parent or Legal Guardian Signature Date

Permission to Photograph

I give permission and consent for Behavior Matters, LLC to photograph my child and/or myself during the time my child is enrolled in services. I understand these photographs may be used in educational training presentations.

Child's name: _____ Date of birth: _____

- _____ _____ _____

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

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

- _____ _____ _____

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

Permission to Videotape or Audiotape

I give permission and consent for Behavior Matters, LLC to videotape and/or audio tape my child and/or myself during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Behavior Matters, LLC and the family.

Child's name: _____ Date of birth: _____

- _____ _____ _____

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

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

- _____ _____ _____

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

RELEASE OF PATIENT INFORMATION

EXPLANATION OF YOUR AUTHORIZATION

For Your Protection	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.
The Privacy of Your Health Records	We understand that information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information and following all laws about its use. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says: 1. We must keep your health care information from others who do not need it. 2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request (a court order would be an example of one of these situations).
Who will see your protected information	The agreement you sign with us may cover health care services you had before now or may have later. We review your health care information and submit claims to payers you have agreements with to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives. We may share your health care information with health plans, insurance companies, and government programs to help you get your benefits and so that we can be paid for your health care services.
Your Access to Protected Health Records	In almost all cases, you may see your health care information. You may ask in writing to receive a copy of your health care information. If you think some of your health care information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your health care information from us. Note: If you are younger than 18 years old and, by law, you are able to give consent for your own health care, then your health care information is kept private from others unless you sign an authorization form.
Others we may share your information with	We follow the law which tells us when we ARE REQUIRED to share health care information, even if you do not sign an authorization form. We may be required to report: 1. contagious diseases, birth defects and cancer; 2. firearm injuries and other trauma events; 3. reactions to problems with medicines or defective medical equipment; 4. to the police when required by law; 5. when the court orders us to; 6. to the government to review how our programs are working; 7. to an insurance company who needs to know if received services from us; 8. to Workers Compensation for work related injuries; 9. birth, death and immunization information; 10. to the federal government during the course of an investigation; 11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults. We may also share health care information for government permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.
Your Right to this Notice	This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days if you are currently receiving services.
Questions & Complaints	If you have any questions regarding the notice or wish to receive additional information about our privacy practices, please contact our office. If you believe your privacy rights have been violated, you may file a complaint at our service location(s) either in person or by mail. We utilize a neutral third party Quality Assurance Liaison to provide you the opportunity to state you're compliant and seek resolution if the nature of a question or complaint makes you feel uncomfortable about approaching our practice directly. This liaison is not our employee and has agreed to maintain your confidentiality while they seek resolution for you through our practice. Our Quality Assurance Liaison is Rebeka Edge, MA, BCBA or Pearl Pena and can be reached by phone or by mail at 907-726-5330, 16941 North Eagle River Loop Road, Eagle River, AK 99577 You may also contact the Department of Health & Social Services Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by e-mailing the state DHSS Privacy Official at: PrivacyOfficial@health.state.ak.us. You can also contact the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. Your health care services will not be affected by any

	complaint made.

As required by privacy regulations created as a result of the Health Insurance Portability/Accountability Act of 1996, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED; AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Within this document the patient is referred to as "you." Most of the individuals who are reading this are parents of a patient. As your child's personal representative, reading this notice will inform you of this agency's policies regarding your child's medical information and how it will be handled.

Commitment to Privacy:
This agency is committed to maintaining the privacy of your protected health information (PHI). We are required by law to maintain the confidentiality of your health information. We also are required by law to provide you with this notice of our legal duties and privacy practices that we maintain in this clinic concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect.

We recognize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your PHI. Your privacy rights regarding your PHI. Our obligations concerning the use and disclosure regarding your PHI.

We May Use and Disclose Your Protected Health Information (PHI) in the Following Ways:

1. Treatment-This agency may use your PHI for treatment purposes. We may disclose your PHI to other health care providers for purposes related to your treatment. This may include, but is not limited to, your doctor, other therapists, caseworker, and school related personnel.
2. Payment-This agency may use and disclose you PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs.
3. Health Care Operations-This agency may use and disclose your PHI to operate our business. An example of this is, using your PHI to evaluate the quality of care you receive from us.
4. Appointment-This agency may use and disclose your PHI to contact you and remind you of an appointment. An example of this is, leaving a message on your answering machine.
5. Release of Information to Family/Friends-This agency may release your PHI to a friend or family member that is involved in your care. For example, if a friend, babysitter, grandparent, or other family member is with you or your child during the session, they may receive medical information about you or that child.
6. Disclosures Required by Law-This agency will use and disclose your PHI when we are required to do so by federal, state, and/or local law.

Uses and Disclosure of your PHI in Certain Special Circumstances:

1. Public Health Risks-This agency may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of reporting child abuse or neglect, maintaining vital records, preventing or controlling disease, injury or disability, notifying a person regarding a potential risk for spreading or contracting a disease or condition, reporting problems with products or devices, notifying individuals that a product or device they may be using has been recalled.
2. Revised 01/19/092. Health Oversight Activities-This agency may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities may include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings-This agency may use and disclose your PHI in response to a court order, if you are involved in a lawsuit or similar proceedings.
4. Law Enforcement-This agency may release PHI if asked to do so by a law enforcement official regarding a crime victim. If we are unable to obtain the person's agreement, concerning a death we believe has resulted from criminal conduct, regarding criminal conduct at our offices, in response to a warrant, summons, court order, or similar legal process, to identify/locate a suspect, material witness, fugitive or missing person, or in an emergency, to report a crime.
5. Serious Threats to Health and Safety-This agency may use and disclose your PHI when necessary to reduce or prevent a serious threat to your or your child's health and safety or the health and safety of another individual.

6. Military-This agency may disclose your PHI if you are a member of US or foreign military forces and if required by the appropriate authorities.
7. National Security-This agency may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. Inmates-This agency may disclose your PHI to correctional institutions or law enforcement officials if you or your child is an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care service to you or your child, for the safety and security of the institution and to protect your health and safety or the health and safety of other individuals.
9. Workers' Compensation-This agency may release your PHI for workers' compensation and similar programs.

Your Rights Regarding Your PHI:

You have the following rights regarding the PHI that we maintain about you or your child. Request involving your rights must be submitted in writing.

1. Confidential Communications-You have the right to request that our agency communicate with you about health-related issues in a particular manner, or at a certain location. The request must specify the method of contact, or the location where you wish to be contacted. We will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting Restrictions-You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care. 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 you. Your request must describe in a clear and concise fashion the information you wish restricted, whether you are requesting to limit our clinic's use, disclosure or both, and to whom you want the limits to apply.
3. Inspection and Copies-You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you or your child, including patient medical records, and billing records. This clinic may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.
4. Amendment-You may ask us to amend your health information if you believe it is incorrect or incomplete. You may request an amendment for as long as the information is kept by or for this agency. You must provide us with a reason that supports your request for the amendment. Also, we may deny your request if you ask us to amend information that is in our opinion accurate and complete, not part of the PHI, not created by our agency, or the individual/entity that created the information is not available to amend the information.
5. Accounting of Disclosure-All of our patients have the right to request an "accounting of disclosures" which is a list of certain non-routine disclosures our agency has made of your PHI for non-treatment, non-payment, or non-operations purposes. Use of your PHI as part of the routine patient care in our clinic is not required to be documented. All requests for an "accounting of Revised 01/19/09 disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before January 31,2011.
6. Right to a Paper Copy of this Notice-You are entitled to receive a paper copy of this notice of privacy practices at any time. A written request is not required.
7. Right to File a Complaint-If you believe your privacy rights have been violated, you may file a complaint with this agency's privacy officer, the Office of Civil Rights, or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.
8. Right to Provide an Authorization for Other Uses and Disclosures-This agency will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of you or your child's PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care.
9. If you have any questions or correspondence-please contact Rebeka Edge, Privacy Office for Behavior Matters, LLC. This agency reserves the right to revise or amend the Notice of Privacy Practices. Any revision to this notice will be effective for any records that this clinic has created or maintained in the past or will create or maintain in the future. Effective January 31, 2011

RELEASE OF PATIENT INFORMATION AUTHORIZATION FROM

PATIENT NAME:	**SSN:**
AKA NAME(S):	**DATE OF BIRTH:**

PEOPLE & ENTITIES I AUTHORIZE TO RECEIVE MY PROTECTED HEALTH INFORMATION	
NAME OF ENTITY	**CONTACT INFORMATION**

Please list medical practitioner(s), spouse, caregiver(s), guardians(s), etc. you are authorizing to receive PHI.

The purpose of this release of protected health information authorization:

I hereby authorize the use or disclosure of my health care and/or other information within my patient record to the entities stated above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section at the bottom of this form, or by notifying *Behavior Matters, LLC* in writing, but if I do, it will not affect actions take on this authorization before my revocation was received. I understand that *Behavior Matters, LLC* will not condition my treatment, payment, or eligibility for services based on whether I provide this authorization.

I understand that if the person(s) or entities I authorize to receive my protected health information are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulation. To the extent that this information is required to remain confidential by federal or state law, the recipients of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event:
Signature of Patient or Personal Representative: Date: (Or Witness if signature is by mark)
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:

NOTE: This authorization was revoked on: _____(see attached revocation), Complete when/if revoked.
Date

A PHOTOCOPY OF THIS AUTHORIZATIONS IS AS VALID AS THE ORIGINAL