ABA Therapy Solutions, LLC
136 Tradewinds Rd.
New Castle, PA 16102

PROSPECTIVE CLIENT

SUBJECT: ABA SERVICES FOR YOUR CHILD

Dear Perspective Client,

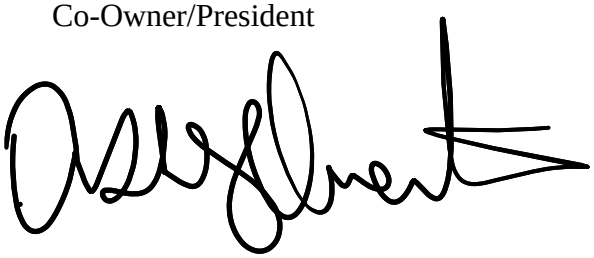
Thank you for your interest in our company. Please complete the Client Registration Form to provide sufficient information to assess how we can be of service. Additionally, please provide a copy of your child's diagnostic evaluations and front and back of your child's insurance card(s). With these two documents we can begin to assess an appropriate path towards beginning treatment.

Once you have completed the documents, please bring them with you the day or your child's scheduled assessment. Please contact one of us if you have any questions or concerns!

Thank you again for your interest in our services and we look forward to working with you.

Sincerely,

Ryan Pastore
Co-Owner/President



Ashley Overton, M.Ed, BCBA, LBS, COBA
Co-Owner/Chief Clinical Officer

Requirements for ABA Services:

1. Completed Intake Packet

_____ General Information

_____ Client Registration Form

_____ History (Psychological/Prenatal/Medical)

_____ Authorization to Release Information

_____ Authorization to Bill Insurance

_____ Informed Consent

_____ Confidentiality Act-Abuse Reporting Protocol

_____ Financial Responsibility

_____ Permission to Videotape and Photograph

_____ HIPPA Service Agreement and Consent Form

_____ IEP

_____ ETR (If applicable)

_____ Psychological Evaluation

2. Pre-approval from insurance company (if applicable) is required prior to any evaluation, therapy, or other service being provided.

3. Intake

- Assessment with ABA Therapy Solutions BCBA or BCaBA
  - FBA, VB-MAPP, ABLLS-R, AFLS etc.

4. Parent Meeting – Development of treatment plan and review of reports, goals

5. Scheduling therapy sessions

6. Direct therapy will be conducted by a Registered Behavior Technician under the supervision of a BCBA or BCaBA

7. Monthly meetings to review progress

8. Quarterly/biannual assessments to continue to guiding instruction

**** Translation Services available upon request****

Mission

Our mission is to provide intensive treatment with the most effective, researched based therapy to make lasting changes in the lives of our clients. We believe in a total team approach to ensure that our clients are able to access the most appropriate services to meet their individual needs. ABA Therapy Solutions, LLC strives to provide the highest quality services for children and young adolescents with autism and other developmental disabilities. The emphasis is always client achievement and maximizing the individuals' potential in the home, school, and the community to create lasting change throughout their lives. ABA Therapy Solutions, LLC is dedicated to abide by the ethical standards outlined by the Behavior Analyst Certification Board.

Philosophy

ABA Therapy Solutions, LLC supports evidence-based treatment methods based in the principles and procedures of Applied Behavior Analysis including but not limited to Verbal Behavior strategies, Natural Environment Training (NET), Fluency Based Instruction, Social Skills Training, Behavior Reduction Procedures and Direct Instruction.

A child's program is **individualized** to meet his/her needs. We first assure that each client meets eligibility requirements and appropriateness for admission to treatment. We then begin treatment planning by completing initial assessments including but not limited to Functional Behavior Assessments, Preference Assessments, VB-MAPP, AFLS, ABLLS, in order to guide instruction and develop the most effective treatment plan possible for each child. Each skill area/domain contains specific curriculum designed to increase each child's functioning and independence. Individual Treatment Plan goals will be established with the collaboration of parents, and/or the home school district, and/or other professionals that form the multidisciplinary team.

Contact Information

Ashley Overton, M.Ed, BCBA, LBS, COBA
Co-Owner/Chief Clinical Officer
Ashley@abatherapyforkids.com

Ryan Pastore
Co-Owner/President
ryan@abatherapyforkids.com

An Overview of ABA/Verbal Behavior Approach to Therapy

ABA Therapy

ABA Therapy Solutions, LLC utilizes the principles of Applied Behavior Analysis and develops individualized programs or treatment plans that target cognitive, speech, language, academic or school readiness, behavior management, play, and social skills. Each individualized program is based on the child's strengths and work to decrease skill deficits.

Applied Behavior Analysis is the study of the functional relationship between one's behaviors and their environment. Data is collected on the stimuli that elicits, increases, decreases, or maintains the child's behavior. The data is analyzed and a treatment plan or an individualized ABA program is implemented. As the child's treatment progresses, data is collected and analyzed again to determine treatment effectiveness. The goal of a behavior analyst is to utilize behavioral contingencies to help the child learn more functional skills that can replace undesirable behaviors and improve quality of life. ABA Therapy Solutions, LLC seeks to produce significant results enabling the child to adapt to their environment thus preparing them for a brighter future.

Evidenced Based Treatment

The long-term outcomes for children and adults diagnosed with an autism spectrum disorder (ASD) are greatly impacted by the types of interventions that they receive. Behavior analysts do not implement non-behavior-analytic interventions. Procedures used in ABA include the use of positive and negative reinforcement, extinction, modeling, shaping, and chaining behaviors. Applied Behavior Analysis programs also include the use of token economies, discrete trials, behavior momentum and self-management techniques, among others.

Individualized Programming/Development

Each child is unique and therefore we believe it is our job to design a behavior intervention program that is individualized to your child's specific needs. Our BCBA's and BCaBA's continually assess each child's needs and use ABA Therapy Solutions extensive researched based curriculum to create a specialized program for each child. Our highly skilled staff members are trained in a wide range of ABA methods so that they have many options to find the intervention that works best to meet your child's specific needs.

Verbal Behavior Therapy

Verbal Behavior Therapy teaches communication using the principles of Applied Behavior Analysis and the theories of behaviorist B.F. Skinner. Verbal Behavior is the actions of a person that are reinforced by a listener. It is a way of understanding the different purposes of language (e.g., a child may use language to ask for things, or to label things in his environment). Each child has their own method of communication – words, signs, augmentative devices, pictures, etc., but all children need to learn to be effective communicators. All skills are examined comprehensively to see if they are emerging evenly across all operants.

Most traditional language approaches differentiate between receptive (listener skills) and expressive (vocal) language. Skinner's functional analysis of verbal behavior further analyzes vocal behavior according to its function. Mand (request), Tact (label) and Intraverbal (talking about things in the absence

of those things) are all components of "expressive language." Focusing on the reasons we say words rather than the form of the response allows us to more effectively teach functional language skills to children with Autism Spectrum Disorder.

Verbal Behavior Therapy (Con't)

The Verbal Operants:

- **Mand** = request (you say it because you want it)
- **Tact** = label (you say it because you see, hear, smell, taste, or feel something)
- **Intraverbal** = conversation, answering a question, responding when someone else talks (you say it because someone else asked you a question, or made a comment)
- **Echoic** = repeating what someone else says (you say it because someone else said it)

Other Operants:

- **Imitation** = repeating someone else's motor movements (you move because someone else moved the same way)
- **Listener Responding/Receptive** = following directions (you do what someone else asks you to do)

Our goal at ABA Therapy Solutions is to help our clients understand that *communicating* produces positive results.

Assessments - VB-MAPP, FBA, ABLLS-R, AFLS, etc.,

VB-MAPP - The VB-MAPP is a developmentally based criterion referenced assessment tool that was field-tested with typically developing children and children with ASD. The VB-MAPP assesses individual skills within each repertoire area, such as the echoic, mand, tact, intraverbal, etc. It also assesses the child's barriers to learning and contains a transition assessment which is to aide providers in making placement decisions about the level of inclusion or group instruction that may be appropriate for that learner. There are five components of the VB-MAPP (Milestones, Barriers and Transition Assessment, Task Analysis and Skills Tracking and Placement and IEP Goals), and collectively they provide a baseline level of performance, a direction for intervention, a system for tracking skill acquisition, a tool for outcome measures and other language research projects, and a framework for curriculum planning. Each of the skills in the VB-MAPP is not only measurable and developmentally balanced, but they are balanced across the verbal operants and other related skills.

FBA - A Functional Behavior Assessment is the primary tool used to identify and attempt to understand a child's behavior. It is a multidisciplinary approach that incorporates a number of techniques, sources of information, and strategies to understand the reasons behind problem behavior and to develop strategies or interventions to address the problem behaviors. The process involves documenting the antecedent (what comes before the behavior), behavior, and consequence (what happens after the behavior) over a number of weeks; interviewing teachers, parents, and others who work with the child; and manipulating the environment to see if a way can be found to prevent the behavior. This information is important because it leads the observer beyond the "symptom" (the behavior) to the student's underlying motivation to escape, "avoid," or "get" something, which is the root to all behavior. The findings from the FBA become the basis for the Behavior Intervention Plan.

ABLLS-R - The Assessment of Basic Language and Learning Skills - Revised is an assessment tool, curriculum guide, and skills-tracking system used to help guide the instruction of language and critical

learner skills for children with autism or other developmental disabilities. The ABLLS-R contains a task analysis of the many skills necessary to communicate successfully and to learn from everyday experiences. It provides both parents and professionals with criterion-referenced information regarding a child's current skills and provides a curriculum that can serve as a basis for the selection of educational objectives.

AFLS - The Assessment of Functional Living Skills (AFLS) is an assessment, skills tracking system, & curriculum guide for the development of essential skills for achieving independence. It can be used to demonstrate a learner's current functional skill repertoire & provide tracking info for the progressive development of these skills. The AFLS contains task analyses of the skills essential for participation in family, community, & work environments.

Other assessments are completed based on the individual needs of each child.

Behavior Intervention Plans

Behavior Intervention Plans are developed from a Functional Behavior Assessment and skill acquisition assessment. Behavior Intervention Plans increase the acquisition and use of new alternative skills, decrease the problem behavior and facilitate general improvements in the quality of life of the individual, his or her family, and members of the support team. Parents are an important team member in developing the treatment plan. Parents will be involved in developing the goals and objectives that are appropriate to their child's life. If there are significant changes made to a treatment plan, parents will be notified and a revision will be completed and signed.

Social Skills Training

ABA Therapy Solutions, LLC provides social skills training to children with Autism Spectrum Disorder and other developmental disabilities. The focus of the program is to increase the child's overall ability to:

- Recognize and interpret verbal and non-verbal communication
- Develop appropriate peer relationships
- Assist individuals with improvement in social interactions by expanding their interest in age appropriate topics, toys and play skills
- Increase their ability to recognize others emotions
- The goal is to minimize stress and anxiety when participating in social interaction.
- The program strives to provide the tools necessary for successful interpretation of social and communication skills.

Functional Communication Training

FCT is used to teach and establish replacement behaviors for inappropriate or harmful behaviors such as aggression, escape/elopement, non-compliance, etc. When a child is regularly engaging in disruptive, challenging behaviors the child is having difficulty communicating or meeting their wants and needs. Even for a verbal child, but particularly for a non-verbal child, behavior is a way of communicating. It is our role to develop a comprehensive ABA program to replace challenging behaviors with more effective and efficient positive/functional behaviors in order to get their needs and wants met in a more socially acceptable manner.

Professional Development Training (Parent/Tutor/Teacher)

ABA Therapy Solutions, LLC offers a wide range of professional development trainings for parents, families and school districts in the area of Applied Behavior Analysis. Our workshops/trainings are available in full day sessions, half day sessions and evening sessions. Workshops and training can be tailored to meet your individualized needs for professional development. Please contact us for more information.

IEP Development and Support

ABA Therapy Solutions, LLC can provide on-going collaboration throughout the Individualized Education Plan (IEP) process, including the construction of IEP goals and objectives, assisting in the implementation of the goals in the home and school settings, and reporting of progress.

Autism Scholarship Students

The Autism Scholarship Program gives the parents of children with autism who qualify for a scholarship the choice to send the child to a special education program other than the one operated by the school district of residence to receive their education and the services outlined in the child's individualized education program (IEP).

Any student who has been identified by their district as a child with autism and for whom the district has created an individualized education plan (IEP) qualifies for the Autism Scholarship program.

The student must have a current IEP from the district of residence that is finalized and all parties, including the parent, must be in agreement with the IEP.
A child is eligible to apply to participate in the program when the child turns three.

The following information is needed for the Autism Scholarship:

Autism Scholarship Application
Copy of student's Birth certificate
*Two Proofs of Address (Copy of a current utility bill with the payment stub attached that is in the primary parent's name with the same address that is on the application.)
Copy of student IEP
Copy of student ETR
Legal documents (For any student that parents are divorced or separated)

_____ Parent/Guardian Initials

Non-Discrimination Policy
ABA Therapy Solutions, LLC does not discriminate against applicants/students on the basis of race, color, national or ethnic origin, religion, ancestry, gender, disability, age, sex, gender identity and expression, or sexual orientation. ABA Therapy Solutions, LLC admits the client/student of any race, color, national or ethnic origin, religion, ancestry, gender, gender identity and expression, or sexual orientation to all the rights, privileges, programs and activities generally accorded or made available to any client/student of the program.

Admission/Withdraw Procedure
ABA Therapy Solutions offers rolling admission, which means there is no application deadline. Qualifying students are admitted throughout the year as long as space permits. In order to begin the admission process, please contact Ashley Overton at 724-730-7633 or Ryan Pastore at 724-730-8726. After the initial phone discussion, a team decision will be made if ABA Therapy Solutions is the right fit for the family and child.

There are three phases to the admission process:
Phase 1:

1. The President or Chief Clinical Officer will conduct a phone conversation with the family to determine the first step in student eligibility.
2. If it appears the admission process may move forward, and the family would like to continue to the next step, Phase II will begin.
3. The resulting factors in each Phase will determine whether or not the admission process may continue to move forward.

Phase 2:
1. An assessment (VB-MAPP, PEAK ASSESSMENT, SOCIAL SKILLS ASSESSMENT, FBA, EDUCATIONAL ASSESSMENT, etc) will take place to determine current functional description along with current skill level.
2. An assessment report will be completed along with a treatment plan to outline an appropriate individualized plan to meet the child's needs and parent training component.

Phase 3:
1. A schedule will be developed and the student and family will meet staff and review plan and treatment procedures.
2. Services will then begin

Withdraw Procedure
ABA Therapy Solutions requires a 30-day notice to make any changes to a student's enrollment in any schedule within the student's educational /treatment plan. Parents will need to contact the Chief Clinical Officer for any changes to educational/therapy schedule. You will be required to complete a written notice of your intent to withdraw and have it signed by the Chief Clinical Officer. In any event that disciplinary action is needed for a student, parents are immediately notified, and a team meeting will be held to try to resolve the issue. If the situation is not resolved and disciplinary actions cannot rectify the situations an IEP placement meeting will be held and the school district officials will be invited in order to determine if a direct district placement is beneficial for all involved. Direct district placements typically allow for additional intervention. The team will further discuss termination of placement if needed and any action needed for future transitioning. A discharge summary will be completed by the student's supervisor.

_____ Parent/Guardian Initials

Parents are encouraged to sign the Approval for Deposit of Scholarship Checks form so that ABA Therapy Solutions may deposit the scholarship checks as they arrive to the clinic. The President will make a copy of the check and mail it home as evidence ABA Therapy Solutions received and deposited each check.

Parent/Staff Communication
Open communication between ABA Therapy Solutions, parents, district staff and other team members is very important to ensure continuity of care. ABA Therapy Solutions values your child's education/therapy needs and takes any concerns you have very seriously. If these should arise, please follow the procedure listed below:

1. Contact your child's supervisor as discussing the issue with the supervisor first can solve many issues. This can be done via email, phone, sending a letter or scheduling a conference.
2. Contact the Chief Clinical Officer. This can be conducted in the ways listed above. The Chief Clinical Officer will determine if a meeting needs to be called with your child's team (such as an IEP meeting) to review the child's plan or any other necessary actions.

   There are various ways our staff communicates with parents about their student's day. Some examples include: daily sheets, communication notebooks, phone call, emails, etc.

School Calendar
At the beginning of the school year, families will be provided with a school calendar that will indicate holidays, ABA Therapy Solutions closings and training/in-services days. The calendar is subject to change with notice to families.

Inclement Weather
On rare occasions, it might be necessary to close ABA Therapy Solutions due to poor weather conditions. If circumstances should arise, we will notify each family as soon as possible.

Attendance for Scholarship Students
Regular attendance is expected of all students and is necessary in achieving consistency and success within the program. No therapy sessions will be made up if your child is absent during this scheduled day. Absences are excusable for illness, appointments, death in the immediate family or celebration of religious holidays. After 2 consecutive sick days, a doctor's excuse is required. Absences for vacations are permitted with written notice to ABA Therapy Solutions.

Lunch/Snack
Parents/guardians will provide lunch/snack for their child. ABA Therapy Solutions can heat food if needed.

Extra Clothing
Please provide a change of clothes in a large Ziploc bag for your child. Clothes will remain in the child's backpack for emergency use. Be sure to include shirt, pants, shoes, socks and extra underwear or diapers. Please sure to have appropriate clothing for each season.

_____ Parent/Guardian Initials

Arrival/Dismissal
Admittance to the clinic before 8:55am will not be permitted. Early pick-up from your scheduled time is only permitted when special arrangements are made.

No child will be released from ABA Therapy Solutions to a person not authorized by a parent. We MUST have written notification or verbal authorization at the time of arrival or dismissal for this change. The person picking up must have proper identification.

Daily Schedules
The following schedule is an example of what the day will look like for clients participating in the school based program:

9:00-9:15 – Arrival/Free Play
9:15-9:45 – Morning Meeting/Circle Time
9:45-10:00 – Small Group Activities
10:00-10:15 – Snack
10:15-10:45 – Music/Art
10:45-11:15 – Small Group Activities
11:15-11:45 – Fine Motor/Gross Motor/Sensory
11:45-12:15 – Lunch
12:15-2:45 – Intense ABA
2:45-3:00 – Free Play/Dismissal

_____ Parent/Guardian Initials

THE FOLLOWING INFORMATION PERTAINS TO ALL ABA THERAPY SOLUTIONS CLIENTS

Parent Guidelines

Your cooperation on the following is greatly appreciated to assist us in working with your child effectively and efficiently:

- If your family is planning an extended vacation (more than 2 weeks), please inform the therapist and supervisor. We will continue to reserve the spot for your child, but cannot guarantee that your child will work with the same therapist.
- In case of an accident or unusual incident, the therapist should complete an incident form and family and Chief Clinical Officer will be informed within 1 working day.
- Sickness. *Please notify the therapist, as much in advance as possible, at least the night, before the scheduled session if you know that your child (or other children in your home) will not be able to participate in the program the next day due to illness.* Sickness includes, but not limited to the following:
    - Temperature above 100
    - Communicable Disease
    - Hand/Foot/Mouth
    - Vomiting
    - Measles, Mumps, Chicken Pox
    - Diarrhea
    - Pin Worm
    - Strep Throat
    - Lice
    - Rash
    - Pink Eye

Parents are asked to use the same guidelines used in a school – if a child **(or sibling)** is too sick to attend school, he or she is too sick to participate in his/her therapy session.

Therapy will resume as soon as the child's doctor clears him/her of being contagious or the remedy is completed. If child arrives sick to the clinic with any of the illnesses listed above, the therapist will not be able to work with your child and you will be contacted to pick up your child.

- Parents and consultants/therapists should be respectful and courteous to each other. Open communication between parents and consultants/therapists is essential to the establishment of a successful program for the child. If there are any problems or concerns, please contact the Chief Clinical Officer immediately.
- Please understand that all information shared is HIPPA protected, it is essential that every ABA Therapy Solutions, LLC employee respects and maintains each client's right to confidentiality regarding his or her treatment and all personal information. **All HIPPA laws apply.** Please do not ask about another clients program or treatment, as this information will not be discussed and could possibly lead to the dismissal of your child from the program.

_____ Parent/Guardian Initials

Scheduling and Sessions

Each client will have a Board Certified Behavior Analyst and may also have an assigned Board Certified assistant Behavior Analyst as the lead supervisor for their treatment. A Behavior Technician will provide direct 1:1 therapy in the designated setting. Each Behavior Technician is registered through the BACB and has experience providing services to children with Autism.

Because we carefully examine several factors to make sure your child receives the most effective, complete, and beneficial care, we are requesting that therapy sessions are no less than 120 minutes per session (evening cases) and no less than 180 minutes per session (day time cases), per scheduled day. We do understand that there are days where a child is ill, has another appointment, or has had some other incident where therapy may end earlier than scheduled.

It is our primary goal to provide quality and consistent services to our clients. To do so we must adhere to the schedule agreed upon by the treatment team. Our agency recognizes that extraneous circumstances occur that result in disruptions to the regular schedule and we are sympathetic. However, consistency is important in order to ensure fidelity of ABA Therapy. Given this, each client is permitted 10 call-off days (unexcused absences) per year. If a child exceeds 10 days, a doctor's excuse is expected for every canceled appointment for the remainder of the year.

Except in cases of emergency, 24 hours' notice is required for all cancelled appointments. We request that families give us at least two weeks' notice on significant changes in their child's schedule to facilitate consistency in service delivery. ABA Therapy Solutions allows a maximum of 2 weeks' vacation time per year. Any absences over 2 weeks of scheduled vacation time may result in a discontinuation of services.

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 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 we obtain your signature acknowledging we have provided you with this information. Although these documents are long and sometimes complex, it is very important you read them carefully and you ask questions regarding the procedures. When signing this document, it will also represent an agreement between our clients/caregivers and ABA Therapy Solutions, LLC. You may revoke this agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed by your health insurer to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations. If you have any questions or concerns, please feel free to bring them to our attention.

_____ Parent/Guardian Initials

Services and Discharge

ABA Therapy Solutions, LLC offers a full-service ABA program. To determine the program needed for a client we initially complete an assessment to determine whether a client would benefit from our services. After it has been determined that our services are needed, a BCBA is appointed as the team leader and develops a treatment plan based on the findings of the assessment.

The treatment plan includes general and specific goals with time frames for completion. The treatment plan also includes a scheduled reassessment generally six months from the time the treatment plan is developed. The treatment plan is then implemented by the BCBA who supervises Behavior Technicians on proper implementation of the treatment plan.

As needed, the program is adjusted by a BCBA to accommodate the client's progress. If the treatment plan is over challenging, the plan will be modified with lower intensity goals. As the client advances through the program more challenging goals can be added to the plan.
If after adjusting the treatment plan and following the updated plan, we may determine our services is not the proper treatment for the client. If such a determination is made, we will follow our discharge and referral protocol.

Once the client has attained a level of development similar to a typical developing child, the client will be put on a maintenance program until the BCBA determines services will no longer benefit the client. Being a sudden stop in services can be detrimental to the skills acquired, the discharge from services is done over a long period of time to achieve a smooth transition.

Appointments

Except for rare emergencies, we will see you (or your child) at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, to avoid any misunderstanding, we ask that you speak to our staff personally and give as much notice as possible to cancel or reschedule. This will allow us to offer our time to another person. You may be charged the standard hourly rate ($50) for appointments missed or cancelled with less than 24 hours advance notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

Confidentiality, Records, and Release of Information

Services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals or agencies.

_____ Parent/Guardian Initials

Family Engagement and Parent Training

ABA Therapy Solutions, LLC, strives for excellence in its ABA program and an integral component to achieve that goal is family involvement and parent training. ABA Therapy Solutions, LLC requires caregivers to carry over the therapy being implemented and record data for specific programs as outlined in the client treatment plan. Parents/Guardians will be trained to implement intervention techniques, to demonstrate understanding of generalization programs, and to generalize the child's skills, behaviors and behavior plans to the natural environment. The Parent/Guardian is expected to carry out all recommendations made to the best of their ability. The Parent/Guardian shall work in a collaborative manner with the BCBA/BCaBA and shall remain informed about the child's current program status on a regular basis in order to demonstrate knowledge of the concepts being taught and to assist with generalization across environments.

In addition to daily onsite trainings within sessions, families will complete monthly family trainings with their BCBA/BCaBA. Parent training is an important part of any ABA therapy program. The ultimate goal for every child is to help them reach their fullest potential. Parent Training aims to help every family learn the skills that they need to keep their child successful at home and in the community.

Families may be asked to attend required training sessions or agency wide trainings throughout the year. Parents may also request training sessions. The amount of parent training that is needed or recommended varies. A typical parent training session lasts one to two hours and is separate from any progress review meetings or daily updates with staff.

If the Client/Family refuses involvement in the treatment plan, as a last resort services may be suspended or terminated based on the severity of the lack of involvement. ABA Therapy Solutions, LLC wants to help all clients we interact with but without the client/family involvement our treatment plans will not be as effective as possible.

Dual Relationships

When implementing intensive therapy hours in any setting, both the provider and family members can cross professional boundaries. Providers/employees must remain professional by keeping conversations exclusively about the child's progress in sessions. Employees should keep conversations and interactions short. Employees are expected to maintain professional boundaries with families at all times, including off work hours. Employees may not socialize with members of the clients' household outside of work hours. Employees of ABA Therapy Solutions may not accept any gifts from or give any gifts to clients because this constitutes a multiple relationship. If needed, please refer to BCBA for answers to extensive clinical questions. Please refer to the Professional and Ethical Compliance Code for Behavior Analysts developed by the BACB for all ethical requirements.

_____ Parent/Guardian Initials

To Protect the Client or Others from Harm

If we have reason to suspect that a client or other minor is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions, which could include notifying the police, and intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

Professional Consultations

Behavior Analysts routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal. We will inform clients of these consultations. If you want us to talk with or release specific information to other professionals with whom you are working, you will need to sign an authorization specifying what information can be released and with whom it can be shared.

Grievance

Discuss verbally or in writing, the grievance (ethical concern) with the clinical supervisor within seven (7) days of the alleged grievance. The clinical supervisor will investigate within seven (7) days after the receipt of such grievance and make every effort to resolve the grievance to the patient's satisfaction.

If the grievance cannot be resolved to the client's satisfaction, the client or his designee is to notify the director in writing. The grievance must state the problem or action alleged and the date the supervisor was notified.

The director will investigate the grievance in an attempt to resolve the difference and notify the client in writing of the resolution of the grievance. The Chief Clinical Officer or President can be reached at:

Ashley Overton, M.Ed, BCBA, LBS, COBA
Ethics Officer
Co-Owner/Chief Clinical Officer
Ashley@abatherapyforkids.com

Ryan Pastore
HIPAA Compliance Officer
Co-Owner/President
ryan@abatherapyforkids.com

If the client/guardian feels his/her grievance has not been resolved after working with ABA Therapy Solutions, he/she is encouraged to notify the Behavior Analyst Certification Board.

_____ Parent/Guardian Initials

Supervision Requirements for Private Pay Clients

- **BCBAs** do not require supervision.
- Our BCaBAs are provided with supervision by a **BCBA** however, our private pay clients are not financially responsible for this supervision.
- Programs implemented by Behavior Technicians require 1 hour of supervision per every 8 hours of direct instruction.

Miscellaneous Services

Additional Services are offered that may include, but not limited to, phone consultation, co-treatments, attendance of school meetings and IEPs, attendance of psychological evaluations, etc.

Cancellation and Late Fees

- Cancellations with less than a 24-hour notification: $50 per appointment (Please refer to our cancellation policy for more details)
- Arrival Late Fees: If a patient is picked up more than 5 minutes late of their scheduled session, a $1.00 per minute late will be charged.

Change in Fee Structure

The fee structure for all services rendered through ABA Therapy Solutions, LLC. is subject to change. Clients will be made aware of such modifications 30 calendar days prior to the effective date of any changes.

Payments

Payment Options. We accept the following forms of payment:

- Cash
- Check
- Credit Card

Invoices are billed on or about the first of each month. Payment is expected by the last day of the month. If payment cannot be paid, please contact Ryan Pastore at 724-730-8726 so that a payment plan can be agreed upon.

Late Payments: If the President is not contacted, a $25 late fee will be assessed on the first of each month that an invoice is not paid.

_____ Parent/Guardian Initials

Wait List Policy & Procedures / Referral to Alternative Therapies

It is ABA Therapy Solutions' goal to provide the highest level of care to children with ASD in the areas we serve and begin therapy as soon as possible. However, from time to time, a client waitlist may develop based on demand for our services, staffing, etc. The following procedures have been established to effectively communicate with our clients and their families:

1. The Chief Clinical Officer / Clinical Supervisor will discuss any potential waitlist challenges during the initial conversation with the clients' caregiver.
2. Families will be updated at least every 30 -60 days or when there are changes to the waitlist.
3. If, after 60 days, it is apparent that the client/family will be placed on the waitlist for an extended period of time, ABA staff will encourage to contact other agencies who can offer similar services (see below).

Professional Records

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in one set of professional records. The Clinical Record includes information about reasons for seeking our professional services; the impact of any current or ongoing problems or concerns; assessment, consultative, or therapeutic goals; progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Personal notes are taken during supervision sessions by the Behavior Technician. While the contents of personal notes vary from client to client, most are anecdotal notes related to progress and future goals, reference to conversations, and hypotheses of the professional. These Personal Notes are kept separate from the Clinical Record are not available to you and cannot be sent to anyone else, including the insurance company. Your signature below waives all rights, now and in the future, to accessing these records in any form under any circumstances. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Patient's Rights

A client has the rights to the following:

1.To be treated with dignity, respect, and consideration;
2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
3. To receive treatment that:
    a. Supports and respects the client's individuality, choices, strengths, and abilities;
    b. Supports the client's personal liberty
    c. Is provided in the least restrictive environment that meets the client's treatment needs;

_____ Parent/Guardian Initials

4. You have the right to practice your religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;
5. You have the right to be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
6. You have the right to be free of any sexual harassment;
7. You have the right to be free of exploitation, including physical and financial exploitation;

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints made about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

Confidentiality of Individual Records

All information obtained about each child and family is confidential. Information can be released only with a written, specific release signed by parents. ABA Therapy Solutions staff members have access to confidential information and are required to demonstrate professionalism. Discussion of the child must be confined to individuals who are professionally involved with the child's enrollment. Any case discussions should be conducted in a professional manner and in an appropriate place, preferably behind closed doors. Children are never to be discussed in public.

There are limits on maintaining confidentiality. ABA Therapy Solutions is a mandated reporter and responsible for the release of student records in the following circumstances:

- Any and all suspected child abuse incidents must be reported
- Any court orders to release records is received
- If you are a danger to yourself or others
- If you waive your rights or give consent
- If the insurance company paying for services requests to review records
- HIPAA Privacy Rule: Disclosures in Emergency Situation

Contacting Us

Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends.). If you are difficult to reach, please leave your availability within the message. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms described above.

_____	_____
Client's Name	Date
_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature

Client Registration Form

Client Information:

Client Name: _____
Address: _____
Social Security No.: _____
Gender: M F Date of Birth: _____

Parent/Guardian Information:

Mother's Name: _____
Address: _____
Date of Birth: _____ Social Security No.: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Occupation: _____ Employer: _____
Insurance Carrier: _____
Policy Number: _____ Group Number: _____
____ Primary Coverage ____ Secondary Coverage

Father's Name: _____
Address: _____
Date of Birth: _____ Social Security No.: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Occupation: _____ Employer: _____
Insurance Carrier: _____
Policy Number: _____ Group Number: _____
____ Primary Coverage ____ Secondary Coverage

Marital Status of Parents: ____ Married ____Separated ____ Divorced ____ Single

Other Insurance Coverage:

Policy Holder: _____
Insurance Carrier: _____
Insurance Policy No.: _____
Insurance Group No.: _____

Client Registration Form

Siblings/Household Members (Other than parent/guardian)

Name: _____
Date of Birth: _____
Relationship: _____

Name: _____
Date of Birth: _____
Relationship: _____

Name: _____
Date of Birth: _____
Relationship: _____

Name: _____
Date of Birth: _____
Relationship: _____

Emergency Contact Information

Name: _____ Phone Number: _____

Relationship to Child: _____

Name: _____ Phone Number: _____

Relationship to Child: _____

Client Registration Form

Related Services (Speech/PT/OT/ABA/Social Services/School Based, etc.):

Name of Provider: _____
Services Provided: _____ From: _____ To: _____
Provider Address: _____
Phone: _____ May we contact: _____ Yes _____ No

Progress Observed: _____
_____

Name of Provider: _____
Services Provided: _____ From: _____ To: _____
Provider Address: _____
Phone: _____ May we contact: _____ Yes _____ No

Progress Observed: _____
_____

Name of Provider: _____
Services Provided: _____ From: _____ To: _____
Provider Address: _____
Phone: _____ May we contact: _____ Yes _____ No

Progress Observed: _____
_____

_____ I hereby authorize ABA Therapy Solutions to release information notifying the new receiving clinician/program of my son/daughter's progress while receiving services from ABA Therapy Solutions.

_____ I do not wish to release information notifying the new receiving clinician/program of my son/daughter's progress while receiving services from ABA Therapy Solutions.

(Office use only) – Please date and initial when information was sent to new receiving clinician/program

_____ Release _____ Informational Packet _____ Assessment

_____ Treatment Plan _____ Progress Reports _____ Other _____

Client Registration Form

Diagnosis: Report Attached (Y / N) Date Filed: _____

Primary Diagnosis 1: _____

Diagnosis Date(s): _____
Diagnosing Professional: _____

Primary Diagnosis 2:

Diagnosis Date(s): _____
Diagnosing Professional: _____

Primary Diagnosis 3:

Diagnosis Date(s): _____
Diagnosing Professional: _____

Medical Conditions (if any): _____
_____

Allergies/Reactions: _____

Diagnosing Professional: _____

Special Diet Information: _____

Current Medications:

Medication	Dosage	Frequency

Client Registration Form

ABA Services Requested:

___ Clinic Based (Day time 9:00-3:00) ___ Clinic Based (After School – 3:00-6:00)

Available Service Times:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

What are your goals and/or expectations for the services requested?

_____

_____

_____

Problem Behavior Information:

Behavior (Please describe)	**Frequency** (hourly, daily, weekly, less often, more often, etc.)	**Duration** (how long does the behavior occur)	**Severity** Mild – Disruptive but little risk Moderate- property damage or minor injury Severe- Significant threat to health or safety

What situations are these behaviors MOST likely to occur? (Days/times/settings/activities/persons present)

_____

_____

_____

_____

Client Registration Form

What situations are these behaviors LEAST likely to occur? (Days/times/settings/activities/persons present)

What typically happens right BEFORE problem behavior occurs?

What typically happens right AFTER problem behavior occurs?

What current treatments are being implemented?

What treatments have been implemented in the past?

What motivates/interests your child?

Client Registration Form

Please list any other important information you would like us to know about your child.

_____
_____
_____
_____

Behavioral Language Assessment
Expressive Verbal Skills

Describe your child's ability to babble speech sounds:

_____
_____
_____

Describe your child's spontaneous language:

_____
_____
_____

Describe how your child indicates what he/she wants:

_____
_____
_____

Describe the type and number of items that your child asks for:

_____
_____
_____

Describe your child's ability to imitate vocal sounds, words, phrases:

_____
_____
_____

Client Registration Form

Describe your child's ability to label items, events, or actions (spontaneous? how many? how often?):

_____
_____
_____

Describe your child's ability to answer questions:

_____
_____
_____

Receptive Language Skills

Describe your child's ability to follow directions and routines within context or with model:

_____
_____
_____

Describe your child's ability to follow directions and routines out of context or without a model:

_____
_____
_____

How many items is your child able to identify receptively? _____

Is your child able to select an item from a field of two or more when given a description of the item? _____

Motor Imitation

Is your child able to imitate simple motor movements such as clapping, waving? Y N

Is your child able to imitate actions using objects---using "do this" with a model? Y N

Your child makes eye contact with (circle all that apply):

Mom Dad Siblings Familiar people Others

Client Registration Form

Describe your child's response when addressed by others:

_____
_____
_____

Describe your child's interest in doing what others are doing:

_____
_____
_____

Describe your child's ability to participate in turn-taking activities:

_____
_____
_____

Is your child conversational? Y N Describe:

_____
_____
_____

Does he/she get "stuck" on certain topics? Y N Describe:

_____
_____
_____

Play Skills

Describe your child's play with toys (identify the toys and length of time involved):

_____
_____
_____

Does your child use the toys as intended or as self-stimulatory objects?

_____
_____
_____

Client Registration Form

Describe your child's interactive play with other children:

_____
_____
_____

Describe your child's imaginative and pretend play skills:

_____
_____
_____

Self-help Skills

Describe how your child feeds him/herself:

_____
_____
_____

Is your child toilet trained completely? Y N

If not, what program did you use or have your tried with your child?

_____
_____
_____

Does your child dress independently: Y N Describe:

_____
_____
_____

Describe any household tasks that your child assists with:

_____
_____
_____

Describe how your child responds to situations of danger:

_____
_____
_____

Client Registration Form

Educational Information:

School: _____ Grade: _____

Address: _____

Contact Name: _____ Phone Number: _____

_____ Home School
_____ Life Skills
_____ Emotional Support
_____ General Education
_____ Learning Support
_____ Speech/Language
_____ Autistic Support
_____ Private School

Please attach the most recent copy of your child's IEP, RR, ETR, FBA and/or BIP.

_____ IEP
_____ RR
_____ ETR
_____ FBA
_____ BIP
_____ Other

Are there any behavioral concerns in school?

_____

_____

_____

Are there any academic concerns?

_____

_____

_____

Psychological History:

Please indicate if there is a history in your immediate or extended family of the following:

Y / N	Diagnosis	Who
	Autism Spectrum Disorder	
	Learning Disabilities	
	ADHD	
	Depression-Manic Depression	
	Behavior Problems in School	
	Anxiety Disorders	
	Psychosis	
	Schizophrenia	
	Substance Abuse/Dependence	
	Other:	
	Other:	

Client Registration Form

Has the child you are seeking services for been evaluated in the past? ____ Yes ____ No
If yes, please list the following information:

Type	By Who	Date	Copy Available (Y/N)

Please provide us with any additional psychological information that may be helpful in developing an individualized treatment plan for your child.

_____
_____
_____

Are there any spiritual or cultural variables that may impact treatment?

_____
_____

Prenatal & Delivery History:

Did the birth mother receive regular pre-natal care? _____ Y _____ N
Were there any complications with the Pregnancy? _____ Y _____ N
If yes, please provide details:

_____
_____
_____

Was the birth full term? _____ Y _____ N
If no, please provide details:

_____
_____

Type of delivery: Spontaneous/Induced Vaginal/C-Section
Birth weight: _____lbs _____oz

Client Registration Form

Concerns at birth? _____ Y _____ N
If yes, please provide details:

_____
_____
_____
_____

Has your child ever had a seizure of unexplained period of unconsciousness? ___Y ___N
If yes, please provide details:

_____
_____

Has your child ever had a head trauma or blow to the head that caused unconsciousness or required medical review? _____ Y _____ N
If yes, please provide details:

_____
_____

Developmental/Medical History:

Please indicate the age at which your child did the following:

Rolled over consistently	_____
Sat up unsupported	_____
Stood	_____
Crawled	_____
Walked unassisted	_____
Said 1st word intelligible to strangers	_____
Said two-three word phrases	_____
Used sentences regularly	_____
Toilet trained during the day	_____
Dry through the night (6+ months)	_____
Dressed self	_____

Client Registration Form

Please indicate if your child is experiencing any of the following:

Problems with eating _____
Isolated socially from peers _____
Problems making friends _____
Problems keeping friends _____
Problems getting to sleep _____
Problems controlling temper _____
Problems sleeping through the night _____
Trouble waking up _____
Fatigue/tiredness during the day _____
Nightmares _____
Bed wetting _____
Soiling _____
Problems with authority _____
Anxiety _____

Developmental/Medical History:

Stress from conflict between parents _____
Legal situations (anyone in the family) _____
History of abuse _____
Alcohol/drug abuse _____
Sadness/Depression _____
School concentration issues _____

List any operations, serious illnesses, injuries, hospitalizations, ear infections or other special conditions your child has had.

_____

_____

Does your child have any vision problems? _____

Last vision exam and by whom?_____

Client Registration Form

Does your child have any hearing problems? _____

Last hearing screen and by whom? _____

Primary Care Physician/Practice: _____

Address: _____

Phone: _____ Fax: _____

_____ I hereby authorize ABA Therapy Solutions to release information notifying my child's PCP that my son/daughter is receiving Applied Behavior Analysis Services.

_____ I do not wish to have my child's PCP notified that my son/daughter is receiving Applied Behavior Analysis Services.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

(Office use only) – Please date and initial when information was sent to PCP

_____ Release _____ Informational Packet _____ Assessment

Comments: _____

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to ABA Therapy Solutions, LLC. I understand that I am financially responsible for any balance. I also authorize ABA Therapy Solutions, LLC or insurance company to release any information required to process my claims and to establish service eligibility/authorizations.

_____ _____

Client's Name DOB

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

Authorization to Release Information

Client Name: _____ DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the supervision of ABA Therapy Solutions, LLC.

I hereby authorize ABA Therapy Solutions, LLC to (check all that apply):

____ Exchange information with
____ Release information to
____ Obtain information from

The following Organization/Individual in regard to the above named patient:

Name of Organization/Individual: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

I hereby authorize this information to be exchanged in the following manner(s):

____ Verbal
____ Written form

Description of information to be exchanged / released / obtained (select all that apply):

____ Education records
____ Evaluation/assessment/eligibility records
____ Medical records
____ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

Other: _____

This information is to be used for diagnostic, treatment planning and continuity of care purposes only.

This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.
From _____(MM/DD/YYYY) To _____MM/DD/YYYY)

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

Records Released by: _____ Date: Released: _____

Authorization to Release Information

Client Name: _____ DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the supervision of ABA Therapy Solutions, LLC.

I hereby authorize ABA Therapy Solutions, LLC to (check all that apply):

____ Exchange information with
____ Release information to
____ Obtain information from

The following Organization/Individual in regard to the above named patient:

Name of Organization/Individual: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

I hereby authorize this information to be exchanged in the following manner(s):

____ Verbal
____ Written form

Description of information to be exchanged / released / obtained (select all that apply):

____ Education records
____ Evaluation/assessment/eligibility records
____ Medical records
____ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

Other: _____

This information is to be used for diagnostic, treatment planning and continuity of care purposes only.

This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.
From _____(MM/DD/YYYY) To _____MM/DD/YYYY)

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

Records Released by: _____ Date: Released: _____

Authorization to Release Information

Client Name: _____ DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the supervision of ABA Therapy Solutions, LLC.

I hereby authorize ABA Therapy Solutions, LLC to (check all that apply):

____ Exchange information with
____ Release information to
____ Obtain information from

The following Organization/Individual in regard to the above named patient:

Name of Organization/Individual: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

I hereby authorize this information to be exchanged in the following manner(s):

____ Verbal
____ Written form

Description of information to be exchanged / released / obtained (select all that apply):

____ Education records
____ Evaluation/assessment/eligibility records
____ Medical records
____ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

Other: _____

This information is to be used for diagnostic, treatment planning and continuity of care purposes only.

This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.
From _____(MM/DD/YYYY) To _____MM/DD/YYYY)

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

Records Released by: _____ Date: Released: _____

Authorization to Bill Insurance

Client Name: _____ DOB: _____

I, _____, hereby give my consent for ABA Therapy Solutions, LLC to bill my/my child's insurance carrier for the services rendered to my child by the above-mentioned provider. In addition, I agree to pay ABA Therapy Solutions, LLC any deductible or uncovered charge in accordance with my health care plan.

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

Authorization to Release Medical Information to Insurance Carrier

I understand that my express consent is required to release any health care information relating to assessment and treatment. I, _____, hereby give my consent for ABA Therapy Solutions, LLC to release medical and other relevant information to our insurance carrier as required by my/our insurance carrier to process medical billings.

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

Informed Consent

Client Name: _____ DOB: _____

I, _____, agree to have my child _____ evaluated/treated through ABA Therapy Solutions, LLC. 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.

I also understand that ABA Therapy Solutions, LLC specializes in the evaluation and treatment of problem behaviors as well as skill acquisition, and if ABA Therapy Solutions, LLC is unable to meet my particular needs, I will be referred to an appropriate agency or individual.

Services: ABA Therapy Solutions, LLC implements the Applied Behavior Analysis for its services. A variety of techniques are integrated and utilized during treatment. You will be encouraged to practice various skills introduced in sessions. A treatment plan with specific goals will be explored and updated according to treatment plan schedules. Recommendations for additional treatment and/or intensive treatment may be made, if needed. **When a client is a minor under the age of 14,** parent involvement is required during all visits with the Client. Information will be limited to accommodate confidentiality with children of all ages. Family involvement is an important part of treatment. Children under the age of 18 will require a parent's signature (or legal guardian) to receive any form of treatment.

Concerns about services may be directed to Ashley Overton, Co-Owner/Chief Clinical Officer at 724-944-3620 or ashley@abatherapyforkids.com.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

Safety-Care Informed Consent

Client Name: _____ DOB: _____

ABA Therapy Solutions' approach to behavioral intervention will utilize Applied Behavior Analysis (ABA) principles. ABA is the use of behavioral methods to measure behavior, teach functional skills, and evaluate progress. A unique plan will be created that results in long-lasting positive outcomes and an enhanced quality of life. Behavioral treatments are clinical processes that involve a professional arrangement. Therapy is regulated by laws, ethics, your rights as a client, and by standard business practices. ABA Therapy Solutions uses least restrictive practices, but in some situations may need to implement more restrictive procedures for immediate safety. ABA Therapy Solutions implements Safety-Care Behavioral Safety Training procedures on an as needed basis and only as a last resort procedure. Least to most restrictive interventions will be implemented as designed by the Safety-Care Curriculum. Safety-Care is a training program for staff working with children, adolescents, or adults who may exhibit challenging or dangerous behavior. All ABA Therapy Solutions staff are trained and certified by a Safety-Care Trainer. A Safety-Care specialist has met the requirements necessary to use the parts of Safety-Care curriculum in which he or she has be trained and certified. The focus in Safety-Care is on prevention, safety and humane, supportive, and evidence-based interventions. Specific Safety-Care procedures that require Physical Management will be included within Behavior Intervention Plans for those clients who may exhibit dangerous behaviors. Physical Safety procedures are not considered restrictive procedures and will be used if a client engages in problem behavior that requires a release to be implemented: Protective Shuffle, Shoulder Check, Wrist Release, Stripping a Grab, Hair Pull Release, Front Choke Release, Bite Release

____ I _____ give my consent for ABA Therapy Solutions to utilize Safety-Care procedures if my child is at immediate risk of harming themselves or others.

____ I _____ give my consent for ABA Therapy Solutions to utilize Safety-Care procedures if my child is at immediate risk of harming themselves or others.

Concerns about services may be directed to Ashley Overton, Co-Owner/Chief Clinical Officer at 724-944-3620 or ashley@abatherapyforkids.com.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

Confidentiality Act – Abuse-Reporting Protocol

Client Name: _____ DOB: _____

Parent/Guardian Name: _____

I understand all information related to the above-named client's assessment and treatment must be handled with strict confidentiality. No information related to the client, either verbal or written, will be released to other agencies or individuals without the express written consent of the client's legal guardian. By law, the rules of confidentiality do not hold under the following conditions:

1. If abuse or neglect of a minor, disabled, or elderly person is reported or suspected, the professional involved is required to report it to the Department of Children and Families for investigation.
2. If, during the course of services, the professional involved receives information that someone's life is in danger, that professional has a duty to warn the potential victim.
3. If our records, our subcontractor records or staff testimony are subpoenaed by court order, we are required to produce requested information or appear in court to answer questions regarding the client.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

_____ _____

Witness Date

Financial Responsibility

Client Name: _____ DOB: _____

For clients who do not have insurance:

- Clients who do not have any insurance coverage are expected to pay on a monthly basis. An invoice will be sent at the beginning of the month following services with an expectation payment is received by the end of the month. A sliding scale may be implemented to accommodate any financial difficulties on a case-by-case basis.
- Clients who are currently covered by insurance: The client is responsible to provide valid insurance information, and should provide their insurance card each visit.
- It is important for you to make sure we are in-network and we are currently a provider with your insurance company.
- If we are currently a provider with your insurance company, the necessary forms will be completed and submitted, and secondary insurances will be billed when applicable.

In Network Plans:

- The client is responsible to pay any co-payment or any portion of the charges as specified by the plan at the time of the visit.
- Any medical services not covered by an individual's insurance plan are the client's responsibility and payment in full is due at the time of the visit. Specific coverage issues should be addressed by the insurance company's member services department (telephone number is on the card).

If you are covered by an HMO or Managed Care Plan:

- The client is responsible to pay any co-payment or any portion of the charges as specified by the plan mentioned above.
- The client is responsible to ensure that any required referrals for treatment are provided to the practice at the time of the visit. Visits may be rescheduled, or the patient may be financially responsible due to the lack of the referral.
- WE reserve the right to charge the completion of forms and letters. For example, insurance, or different programs, and the copying of records.
- Any outstanding balance either not paid in full or under a payment plan agreement can be transferred to an outside collection agency.

A "no show"/late cancellation fee may be charged to clients who do not provide at least 24 hour notice for cancelling scheduled appointments or who fail to keep scheduled appointments without calling to notify the scheduling secretary or clinician.

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

_____ _____
Witness Date

Permission to Photograph

Client's Name: _____ DOB: _____

☐ I give permission and consent for ABA Therapy Solutions, 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.

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

_____
Date

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

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

_____
Date

Permission to Videotape or Audiotape

☐ I give permission and consent for ABA Therapy Solutions, 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 ABA Therapy Solutions, LLC.

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

_____
Date

Emergency Contact Information Form

This information will be extremely important in the event of an accident or medical emergency.

Client's Name: _____DOB: _____

Address: _____

Mother's Name: _____ Phone: _____

Mother's Email: _____ Additional Phone: _____

Father's Name: _____ Phone: _____

Father's Email: _____ Additional Phone: _____

EMERGENCY CONTACT OTHER THAN PARENTS

Emergency Contact Name: _____ Relationship: _____

Phone: Home: _____ Cell: _____ Work: _____

Emergency Contact Name: _____ Relationship: _____

Phone: Home: _____ Cell: _____ Work: _____

Emergency Contact Name: _____ Relationship: _____

Phone: Home: _____ Cell: _____ Work: _____

Preferred Local Hospital: _____

Insurance Name: _____ ID Number: _____

Comments (include any special medical or personal information you would want an emergency care provider to know – or special contact information:

_____

_____

_____

Signature: _____ Date: _____

Health Insurance Portability and Accountability Act (HIPAA)

Notice of Privacy Practices

This notice describes how protected health information about a client may be used and disclosed and how the client can gain access to this information. Please review it carefully.

ABA Therapy Solutions, LLC understands we collect private and/or potentially sensitive medical information about each client and/or the client's family. We call this information "protected health information." This notice explains the client's privacy rights and addresses how ABA Therapy Solutions, LLC may use and disclose protected health information. ABA Therapy Solutions, LLC does not use or disclose protected health information unless permitted or required to do so by law. ABA Therapy Solutions, LLC must adhere to laws aimed at securing the privacy of the client's protected health information. These laws are known as the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. When we do use or disclose protected health information, we will make every reasonable effort to limit its use or the level of disclosure to the minimum we deem necessary to accomplish the intended purpose. Please note that the privacy provisions articulated in this notice do not apply to health information that does not identify the client or anyone else. For more information on ABA Therapy Solutions, LLC privacy practices, or to receive another copy of this notice, please contact:

ABA Therapy Solutions, LLC
136 Tradewinds Rd.
New Castle, PA 16102
724-730-7633 or 724-730-8726

Protected Health Information

Protected health information is information about the client relating to a past, present, or future mental health condition, or treatment or payment for the treatment that can be used to identify the client. This includes any information, whether oral or recorded in any form, that is created or received by ABA Therapy Solutions, LLC. This also includes electronic information and information in any other form or medium that could identify the client. Examples of information that can identify a client include, but are not limited to the following:

Client's Name
Telephone Number
Address
DOB
Social Security Number
Service State/End Date
Diagnosis

Health Insurance Portability and Accountability Act (HIPAA)

Uses and Disclosures of Health Information for Treatment, Payment, and Health Care Operations

1. Treatment, Payment, and Health Care Operations

The following section describes different ways we use and disclose protected health information for treatment, payment, and health care operations. Not every possible use or disclosure will be noted, and there may be incidental disclosures that are a byproduct of the listed uses and disclosures.

a. Treatment

We may use a client's protected health information to provide the client with services, and may disclose this information to any and all ABA Therapy Solutions, LLC staff involved with the client's treatment. Treatment includes (a) activities performed by ABA Therapy Solutions, LLC personnel in the course of providing service to the client or in coordinating or managing the client's service with other service providers and (b) consultations with and between ABA Therapy Solutions, LLC staff and other professionals involved in the client's treatment

b. Payment

We may use and disclose the client's protected health information so we may bill and collect payment from the client, an insurance company, or another party for services ABA Therapy Solutions, LLC provided to the client. We may also inform the client's health plan provider of treatment we intend to administer to obtain prior approval or to determine whether the client's plan will pay for the treatment.

c. Health Care Operations

ABA Therapy Solutions, LLC may use and disclose the client's protected health information in order to maintain necessary administrative, education, quality assurance, and business functions. For example, we may use a client's protected health information to evaluate the performance of our staff in providing treatment for the client. We may also use information about clients evaluate what additional services to offer, how we can improve efficiency, or the effectiveness of certain treatments. Additionally, we may use protected health information for review, analysis, and other teaching and learning purposes.

2. Special Circumstances

Treatment, payment, and health care operations further include the circumstances listed below.

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a. Appointment Reminders

We may use and disclose the client's protected health information to contact the client as a reminder that he/she may have an appointment for treatment or services.

b. Treatment Information

We may use and disclose the client's protected health information to contact him/her about treatment information.

c. Satisfaction Surveys

We may use and disclose the client's protected health information to contact him/her about ABA Therapy Solutions, LLC satisfaction surveys.

3. Uses and Disclosures You Can Limit

a. ABA Therapy Solutions, LLC Client Directory

Unless the client notifies us that he/she objects, we may include certain information about him/her in ABA Therapy Solutions, LLC Client Directory in order to respond to inquiries and disseminate information more efficiently. This directory is accessed by ABA Therapy Solutions, LLC staff who may or may not be involved in the client's treatment.

b. General Notification

Unless the client notifies us that he/she objects, we may provide his/her protected health information to individuals such as the client's family members, caregivers, and friends, who are involved in the client's treatment or who pay for the client's treatment. We may do this if the client informs us we have their consent to do so, or if the client knows we are sharing the client's protected health information with these individuals and the client expresses no objection or makes no reasonably discernable attempt to prevent us from doing so. There may also be circumstances when we can assume, based on our professional judgment, the client would not object to disclosure of his/her protected health information. Also, if the client is not able to approve or object to disclosures, we may make disclosures to a particular individual (such as a client's family member or friend), we feel are in the client's best interests and that relate to that person's involvement in the client's care.

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OTHER PERMITTED USES AND DISCLOSURES OF HEALTH CARE INFORMATION

We may use or disclose the client's health information without the client's permission in the following circumstances, subject to all applicable legal requirements and limitations:

1. Required By Law

ABA Therapy Solutions, LLC must make any disclosures required by federal, state, or local law. These may include, but are not limited to, disclosures pertaining to: the reporting of abuse or neglect; court orders, subpoenas, warrants, or other lawful processes; identification/location of a suspect, fugitive, witness, missing person, or crime victim; crime on our work premises; or a serious, imminent threat. Employees of ABA Therapy Solutions, LLC are designated as Mandated Reporters.

2. Public Health Risks

We may make disclosures for public health reasons in order to prevent or control disease, injury, or disability; or to report births, deaths, disease or condition, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

3. Health Oversight Activities

We may disclose protected health information to agencies authorized to receive reports for health oversight activities for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.

4. Lawsuits, Disputes, or Other Legal Proceedings

We may make disclosures in response to a subpoena or court or administrative order, if the client is involved in a lawsuit or dispute, or in response to a court order, subpoena, warrant, summons or similar process, or if requested to do so by law enforcement.

5. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose information to a coroner or medical examiner, (as necessary, for example to identify a deceased person or determine cause of death) or to a funeral director, as necessary to allow him/her to carry out his/her activities.

6. Research

We may use or disclose protected information for research purposes under certain limited circumstances. Research projects are subject to approval by an institutional review board. Therefore, we will not use or disclose the client's protected health information for research purposes until the particular research project, for which the client's information may be used or disclosed, has been approved through the institutional review board.

7. Serious Threat to Health or Safety; Disaster Relief

We may disclose information to appropriate individual(s)/organization(s) when necessary (a) to prevent a serious threat to the client's health and safety or that of the public or another person, or (b) to notify the client's family members or persons responsible for the client in the course of a disaster relief effort. We will disclose protected health information only to persons we believe to be able to lessen/prevent the threat and will limit disclosure to that which we deem necessary to lessen or prevent the threat.

8. Military and Veterans

We must make disclosures as required by military command or other government authority for information about a member of the domestic or foreign armed forces.

9. National Security; Intelligence Activities; Protective Services

We may disclose information to federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.

10. Correctional Facilities

We may make disclosures to a correctional facility (if the client is a ward) or a law enforcement official (if the client is in that person's custody) as necessary (a) for the institution to provide the client with treatment; (b) to protect the client's or others' health and safety and the security of the correctional facility.

WHEN WRITTEN AUTHORIZATION IS REQUIRED

Other than for the range of purposes previously identified in this notice, we will not use or disclose the client's protected health information for any purpose unless the client provides us with specific written authorization to do so. If the client grants us authorization, the client can still withdraw this authorization at any time, though the authorization must be revoked in writing. In order to withdraw the authorization, the client must deliver, mail or email to:

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ABA Therapy Solutions, LLC
136 Tradewinds Rd.
New Castle, PA 16102
724-944-3620 or 724-730-8726

If the client revokes the authorization, we will discontinue the use or disclosure of the client's protected health information to the extent that we relied on his/her authorization for the use/disclosure. However, we cannot take back or undo any use/disclosure made under the client's grant of authorization prior to our receipt of the client's written revocation of that authorization, and we must continue any use/disclosure that is necessary in keeping records of the client's treatment.

THE CLIENT'S RIGHTS REGARDING THE CLIENT'S HEALTH INFORMATION

The client has certain rights regarding his/her health information, which are listed below. In each of these cases, if the client wants to exercise his/her rights, the client must do so in writing by completing a form the client can obtain from ABA Therapy Solutions, LLC. In some cases, we may charge the client for the costs of providing materials to the client. The client can get information about how to exercise his/her rights and about any costs that we may charge for materials by contacting us.

1. Right to Inspect and Copy

With some exceptions, the client has the right to inspect and get a copy of the client's protected health information that may be used to make decisions about the client's care. We may deny the client's request to inspect and/or copy information in certain limited circumstances, and, if we do this, the client may ask that the denial decision be reviewed.

2. Right to Amend

The client has the right to amend his/her health information maintained by ABA Therapy Solutions, LLC, or used by us to make decisions about the client. We will require that the client provide a reason for the request, and we may deny the request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment), (b) is not part of the health information we keep, (c) is of a type the client would not be permitted to inspect and copy, or (d) is already accurate and complete.

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3. Right to an Accounting of Disclosures

The client has the right to request an accounting of disclosures. An accounting is a list of certain disclosures we made regarding the client's protected health information. The list does not include all disclosures. For example, it does not include disclosure to the client, disclosure for treatment, payment, and health care operations purposes described above, or disclosure made with the client's authorization as described above.

4. Right to Request Restrictions

The client has the right to request a restriction or limitation on the health information we use or disclose about the client (a) for treatment, payment, or health care operations, or (b) to someone who is involved in the client's care or the payment for it, such as a family member or friend. We are not required to agree to the client's request. Any time ABA Therapy Solutions, LLC agrees to a restriction, it must be in writing and signed by the Chief Clinical Officer or her designee.

5. Right to Request Confidential Communications

The client has the right to request we communicate with the client about health matters in a certain method or at a certain place. For example, the client can ask that we only contact the client at home or by mail.

6. Right to a Paper Copy of This Notice

The client has the right to a paper copy of this notice, whether or not the client may have previously agreed to receive that notice electronically.

Questions and/or Complaints
If the client has any questions about this notice, he/she should contact:

Ryan Pastore - HIPAA Compliance Officer
136 Tradewinds Rd.
New Castle, PA 16102
724-730-8726

If the client believes his/her privacy rights have been violated, the client may file a complaint with ABA Therapy Solutions, LLC using the contact information provided above. To file a complaint with the Secretary of the Department of Health and Human Services, call (877) 696-6775.

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If the client believes his/her privacy rights have been violated, contact:

Office of Civil Rights, Medical Privacy Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. HHH Building, Room 509H
Washington, D.C. 20201
Phone: (866) OCR-PRIV (627-7748) TTY: (886) 788-4989 www.hhs.gov/ocr

The client will not be penalized for filing a complaint and the client will continue to have the same access to ABA Therapy Solutions, LLC services.

Acknowledgement and Receipt

I acknowledge that I have received a copy of ABA Therapy Solutions, LLC Notice of Privacy Practices. I further acknowledge that I have reviewed and understand the information presented in this notice, including the appropriate contact information for the party(ies) I should contact in the event that I have any further questions, concerns, requests, or complaints regarding any of the covered subject matter.

Client's Name: _____DOB: _____

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

_____ _____
Witness Date