ABA SERVICES

STARBRIGHT

PARENT PACKET

Parent/Guardian Acknowledgement Form

I_____, acknowledge receiving from StarBright ABA the documents listed below and hereby acknowledge that I have read and understand the contents thereof.

- Notice of Privacy Practices for Protected Health Information:
- Your Health Information Rights (to be signed by you):
- A list of Frequently Asked Questions:
- Parent Participation Form (to be signed by you):
- Caregiver Involvement handout:
- Authorization for exchange of Information (completed and signed by you):
- Payment Policy (to be signed by you):
- Credit Card Authorization Form (completed and signed by you):
- Applied Behavior Analysis (ABA) Program. What is ABA (for your reference):)
- StarBright ABA Policies and Procedures (initialed and dated):
- Referrals, Diagnosis, Evaluation, and Insurance Form (to be signed by you):
- Informed Consent (to be signed by you):
- Service Agreement and Consent Form (to be signed by you):
- Patient Confidentiality Contract Form (to be completed by you):
- Request/Authorization to Release Confidential Medical & Mental Health Records and Information (to be completed by you):
- Rules and Regulations (to be signed by you):
- Photographs & Videos (to be signed by you):

- Parent's Guide to ABA Therapy Authorizations, Assessment, and Treatment (for your reference):
- Sunscreen Consent (to be completed by you):
- Discharge Transition Policy (to be signed by you):
- StarBright Cancellation Policy (to be signed by you):
- Emergency Medical Authorization (to be signed by you):
- Peanut Free/Nut Free Facility Form (for your reference):
- Allergy Disclosure Form (to be signed by you): and
- Email & Texting Consent Form (to be signed by you):
- Client Pick up Authorization Letter (to be signed by you):
- INFORMED CONSENT FOR ABA (Applied Behavior Analysis) SERVICES
- Coordination of Care between Behavioral Health and Primary Care Providers

_____ _____

Signature of Parent or Guardian Date

Please provide to StarBright the following documents (if available) with your completed packet:

- Current or most recent IEP/IFSP
- Copies of psychological reports with diagnosis
- Recent Assessments/evaluations

Notice of Privacy Practices for Protected Health Information
Effective Date: August 1, 2014

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!

StarBright is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, behaviors, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A behavior analyst may use your health information to provide you with services.
- A behavior analyst may obtain treatment information about you and record it in your client file.
- During the course of your treatment, the behavior analyst may need to consult with other professionals or individuals (e.g., Physicians, social workers, educators, family members, etc.) involved in your medical care or treatment. He/She will obtain authorization to share your personal information with these individuals.
- Your health information may be shared with other clinical staff within the company for additional support in developing your treatment program

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other agencies/businesses helping us obtain payment) requests information to them about you and the services provided.

Example of Use of Your Health Information for Healthcare Operations Purposes:

We may use your Healthcare Information for internal quality assessment and improvement purposes, audits, insurance appeals, and/or billing disputes.

Your Health Information Rights

The health and billing records we maintain are the physical property of StarBright. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by contacting our office -- we are not required to grant the request, but we will comply with any request granted;
- Request a restriction on disclosure of medical information to a health plan for purposes of carrying out payment or health care operations and is not for purposes of carrying out treatment; and the Protected Health Information ("PHI") pertains solely to a health care service for which the provider has been paid out of pocket in full - we must comply with this request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by contacting our office;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

  Is not part of the health information kept by or for the office;
  Is not part of the information that you would be permitted to inspect and copy; or,
  Is accurate and complete.
  If your request is denied, you will be informed of the reason for denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not

include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your lations, condition, or your death;
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.
- Elect to opt out of receiving further fundraising communications from the office.

If you want to exercise any of the above rights, please make an appointment with our Director at 845-863-5208 to make a request in person or in writing, during regular business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices to the extent permitted by law and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Alisa Lanzetta, Clinical Director, (845)863-5208**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by mailing the written complaint to **12 Winston Pl. Marlboro, NY 12542**

- We cannot, and will not, require you to waive the right to file a complaint as a condition of receiving treatment from StarBright Applied Behavior Analyst, PLLC.
- We cannot, and will not retaliate against you for filing a complaint.

Other Disclosures and Uses

Communication with Family

• Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research

proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

Other Uses

- Other uses and disclosures besides those identified in this Notice will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

StarBright Applied Behavior Analyst PLLC.

Name of Client:_____

Client Date of Birth:_____

Notice of Privacy Practices Acknowledgement

I acknowledge that I have received a copy of the HIPAA privacy practices.

_____ _____

Signature of Client/Client Representative DateThe client has

_____

Relationship to Client

Documentation of Good Faith Efforts

To obtain client's acknowledgment that they received provider's Notice of Privacy Practices (for use when acknowledgement cannot be obtained from the client)

On___/___/___, the client was provided a copy of Notice of Privacy Practices. A good faith effort was made to obtain from the client a written acknowledgment of his/her receipt of Notice. However, such acknowledgment was not obtained because:

___ Client refused to sign

___ Client was unable to sign or initial because:

_____

___ The client had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

___ Other reason (describe below):

_____

_____

_____ _____

Signature of Employee Completing Form Date

Frequently Asked Questions

I need to go and pick up my other child can I leave my child alone with the therapist?

- *No, someone 18 years or older must be present while services are being given in your home.*

My child has difficulty navigating playground equipment and approaching peers at the park. Can my therapist take my child to the park?

- *Yes, in Early Intervention services and ABA can be provided in the home, office or in the community, depending on your child's needs. It may be beneficial to work on specific targets in the home then generalize them to the community. If you are going into the community you or another adult 18 years or older must be present. If your child is in CPSE/CSE then service location will be indicated on the IEP. If your child does not have community indicated on the IEP then services cannot be delivered there. To add community to your child's IEP you must contact the CPSE/CSE chairperson for your school district.*

Can my therapist bring their own children to the session in order to work on social skills?

- *No, at no time should a therapist bring their own child to a therapy session.*

Can my therapist use an iPad/iPod touch to teach my child?

- *Yes, the iPad/iPhone/iPad touch/Smart Devices may be used on a limited basis during therapy sessions as a reinforcing item or to generalize skills. At no time should these devices be used to teach skills that are on an IFSP/IEP or any pre-requisite skills that lead up to an IFSP/IEP goal unless specified on the child's IFSP/IEP.*

Why is my child's therapist asking me for food?

- *Food may be used initially with children who have limited items/toys that act as reinforcers. The food items you provide the therapist with will only be used in small quantities during the first few sessions to condition the therapist with reinforcement and to condition other toys as reinforcers. It is important that your child have a wide variety of reinforcers. If at any time you do not want the therapist to use food please let the therapist know.*

I feel that my child needs an increase/decrease in services. What do I do?

- *If you suspect a change in services is needed, you will need to contact your service coordinator (for EI) or your chairperson for the CPSE/CSE (for preschoolers or school age children). At that point StarBright ABA will request specific documentation from the therapist which will detail why that increase/decrease in services is warranted. Once that change is authorized by the Department of Health (DOH) or the school district and the appropriate documentation is received your therapist will be notified as to when the change in service can be made. Something to consider when you think an increase in services is needed is that "more is not always better". Discuss your concerns with your therapist so that as a team you can look at the pros and cons of an increase in services.*

What do I do my therapist is showing up late consistently/cancelling sessions?

- *Please contact the ABA Field Program Supervisor for your area; please see the included phone contact information sheet.*

Why isn't my therapist bringing in/leaving toys for my child?

- *Your therapist may choose to bring some items in initially when working with your child. But is important that your child learn how to play with the toys in his/her environment. This is important because what you want to see is that the child generalizes these skills when the therapist is not there. If your therapist brings in toys to work with your child keep in mind that this is in part to help condition him/herself with reinforcement as well as to help develop programming. The amount of toys and the type of toys may change as they begin to work with your child.*

Parent Participation Form

All parents complete StarBright ABA's intake packet which includes the following participation form:

Dear Parents:

Your child's success is contingent upon the family's participation in the ABA program. All of StarBright ABA's therapy programs have expirations; therefore, our objective is to work, hand in hand, in order to provide you with the tools in which to carry out your child's goals. Each program will have required parent involvement goals. Parent participation is required in 100% of all provided sessions and locations (i.e., within the home and community settings) and throughout the entire duration of services. It is our expectation and StarBright Expectations that parents will take an active role and assist their child in generalizing and maintaining learned skills within the natural environment. Within the Behavior Intervention program, the parents are provided three notifications regarding lack of parent participation before services are terminated. The three notifications are as follows:

First Notification: Verbal and written warning from the clinical team.

Second Notification: Clinical meeting with your child's clinical team (therapist and supervisor) and the parents/caregivers.

Third Notification: The funding source coordinator is contacted and informed about the lack of parent participation in the behavior intervention program.

If you have any questions or concerns regarding your child's program please contact Alisa Lanzetta, Program Director. We look forward to working with your family.

Sincerely,

StarBright Staff

I agree to fulfill all parent participation requirements specified by my child's program.

_____

Name of Child Service

_____

Name of Parent(s) or Legal Guardian Sign and Print

Caregiver Involvement

Observations and participation by parents/caregivers are welcome! Your participation as partners in the education process is an important component of your child's services. Your lead therapist and service coordinator will provide you with information so you can follow through in the absence of the therapist/therapist. Your therapist will take time during each session to coach you through techniques so that skills may be carried over throughout the day during daily routines when the therapists aren't there. Questions and comments are encouraged and therapists will try to answer questions as much as possible during the session and when coaching. Specific questions/comments that may require more time to answer may be answered more thoroughly at the end of the ABA session.

Some other helpful tips:

1. ***Be ready and available when therapists arrive***. Child is awake, diapered or toileted, and feeding has been completed (unless a part of the instruction.) **Also, someone 18 years of age or older must be in the home while services are being given. There are no exceptions to this policy.**
2. ***Communication is the key to a successful program:*** Communicate often with your team. There will be a communication notebook, review it after sessions. In addition, bring up your questions at team meetings. You can always call your therapists too! Speak with them about the best time and number to reach them.
3. ***Family involvement is a major factor in treatment success***. We believe parent and family participation is an integral part of the assessment process and the basis for successful therapeutic intervention. Family members are essential in the learning and social/emotional growth of any child in a home-based program. Family members are an integral part of the planning, prioritizing, and the progress of every child.

What should you do when your child is sick?

1. If your child has a clear runny nose which needs to be wiped frequently or is incessantly coughing, please cancel the session.
2. If your child's nose is not running clear, it is a sign of an infection and the session needs to be cancelled.
3. If your child is running a fever, or displays viral symptoms of diarrhea or vomiting, sessions need to be cancelled up until 24 hours after fever breaks or symptoms are relieved.
4. If your child has a rash, pink eye, chicken pox, lice or any other highly contagious condition, please cancel the session. Then obtain a doctor's note stating that your child is no longer contagious in order for the clinician to return.
5. Please keep in mind that if your child did not go to school because he/she was sick, then home based services should be cancelled as well.

StarBright Applied Behavior Analyst PLLC.

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Name:_____ SS#: _____

Date of Birth:_____ Telephone
HM#_____WK#:_____

Street Address:_____ City:_____ State:_____ Zip:_____

I hereby authorize the two agencies and/or persons listed below to exchange information regarding my case.

Agency &/or Person:

_____

Street Address_____ City:_____ State:_____ Zip: _____

Phone: _____ Fax:_____ Email: _____

Agency &/or Person:

_____

Street Address: _____ City:_____ State:_____ Zip: _____

Phone: _____ Fax:_____ Email: _____

The initialed information listed below may be released:

_____ All records/Information _____ Psychological Evaluation(s), IQ Scores & Tests

_____ Dental _____ School Records

_____ Medical Records, including Diagnosis _____ Social History

_____ Program Plans, Evaluations & Assessments _____ Other

This information may be released in the following format(s): ____ Electronic ____Verbal ____Written _____Other

I understand the information in my health record may include information relating to sexually transmitted infections, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse.

I understand that this authorization may be revoked by the person served and/or their guardian at any time except to the extent the action has already taken place. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the office manager. Unless otherwise revoked, this authorization

will expire on _____/_____/_____. (Not to exceed one year from the date of signature).

I have read the above authorization for Release of Information/Permission to Obtain and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this release.

Date: _____ Signature of Person Served:_____

Date:_____ Signature of Authorized Representative:_____

Printed Name of Parent/Guardian or Authorized Representative:

_____

Street Address:_____ City:_____ State:_____ Zip:_____

Phone: _____ Relationship to Person:_____

StarBright Payment Policy

I, _____, agree to pay **StarBright ABA** for all services rendered and agree to abide by the following guidelines:

Payment. I understand I will receive an invoice on a monthly basis for services rendered me by Star Bright ABA and are payable at presentment. Cash or credit will be accepted for all payments due on the date indicated on the invoice.

Funding sources. If my insurance carrier provides financial assistance for services, I understand I must pay the fees by the due date indicated on the invoice and allow the insurance carrier to reimburse me for the services unless a current authorization for insurance to cover the amount is on file. I also understand I am responsible for any copayment or coinsurance amounts due on the date indicated by invoice. I understand and agree that I am primarily responsible for the payment of StarBright ABA invoices regardless of whether my insurance carrier covers all or part of the insurance claim generated by StarBright.

Nonpayment. If my account is over **90 days** past due, I will receive a letter stating that I have **20 days** to pay my account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Returned check/insufficient funds. I understand I will be charged a fee of **$35** for any returned checks.

Missed appointments. In the event of emergency situations, I must provide **24 hours** notice to my primary contact person at StarBright in order to cancel an appointment or I will be billed personally for the **full amount** of the session. In the event of an unexpected illness in which **24 hours** notice cannot be made, I am required to provide at least a **2 hours** notice prior to the start of a scheduled appointment in order to prevent being billed for the **full session**. I understand that when a client arrives late to a scheduled appointment, the client is billed the rate of the full appointment. Repeated

failures to attend scheduled sessions or frequently arriving late to scheduled sessions may result in termination of services.

Errors and/or Disputes. I agree to review each StarBright invoice upon receipt and to promptly bring any errors, disputes, and questions or concerns to the attention of StarBright. I understand and agree that my failure to bring errors and/or disputes to the attention of StarBright within (20) days of the date of the invoice shall constitute a waiver thereof.

I have read and understand the payment policy:

_____ _____

Signature of client or guardian Date

StarBright Applied Behavior Analyst PLLC.

Credit Card Authorization Form

Name on Card:_____

Card Type: _____M/C _____Visa _____Amex_____

Account Number:_____

Expiration Date: _____

Security Code:_____

Billing Address_____

_____

Phone Number: _____

Email address: _____

Amount to be billed: _____

By signing this form you authorize StarBright ABA to charge your card for the amount listed above.

Signature: _____ Date:_____

StarBright Applied Behavior Analyst PLLC

SUNSCREEN CONSENT FORM

I hereby give permission for _____ to carry and use sunscreen while receiving services from StarBright ABA and to use it throughout the day. If my child needs help applying or re-applying sunscreen, I give permission for StarBright ABA staff to provide my child with assistance if he/she requests it.

_____ _____

Signature of Parent/Guardian Date

A copy of this Sunscreen Consent Form shall be maintained by StarBright ABA with your child's records.

StarBright Applied Behavior Analyst PLLC

Discharge/Transition Policy

Continuing Stay Criteria

All of the following criteria are necessary for continuing treatment at this level of care:

- The individual's condition continues to meet admission criteria for Applied Behavioral Analysis, either due to continuation of presenting problems, or appearance of new problems or symptoms.
- There is a reasonable expectation that the individual will benefit from the continuation of ABA services.
- Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. The treatment plan is updated based on treatment progress including the addition of new target behaviors.
- All services and treatment interventions are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Expected benefit form all relevant modalities is documented.
- Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms or there are clear benefits to treatment, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
- There is documented skills transfer to the individual and treatment transition planning from the beginning of treatment.
- There is a documented active attempt at coordination of care with relevant providers/caretakers, etc. when appropriate. If coordination is not successful, the reason(s) are documented.
- Unless contraindicated, family and/or significant others are actively involved in the treatment as required by the treatment plan, or active efforts being made and documented to involve them.

Discharge Criteria

The decision to discharge is a difficult clinical decision. This decision is not made without a careful review and analysis of the information regarding the child's condition and progress. Careful consideration is taken to ensure the needs of the child are at the center of the decision made. Children learn in various ways and in various settings with various people. Our goal is to teach children and prepare them for learning in naturalistic settings. Unfortunately, not all children with autism will achieve this with ABA therapy. If ABA is not helping the child learn, or is not needed to help the child learn then discontinuing ABA is the best interest of the child.

These will be the guidelines for the implementation of this policy:

Any of the following criteria are sufficient for discharge from this level of care:

- The individual has achieved adequate stabilization of the challenging behavior and less-intensive modes of treatment are appropriate and indicated.
- The individual no longer meets admission criteria, or meets criteria for a less or more intensive services.
- Treatment is making the symptoms persistently worse.
- The individual is making progress towards treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement or stabilization of challenging behavior and there is no reasonable expectation of progress.
- At the request of the family; or if the child is unable to participate because of medical, social, or psychological difficulties.

_____ _____

Signature (Parent/Guardian) Date

_____

Printed Name (Parent/Guardian)

StarBright Applied Behavior Analyst PLLC

Cancellation Policy

StarBright is pleased that you have chosen us as your ABA provider. Our goal is to provide quality programming for your child as he/she works towards reaching their full potential. The most important way to ensure that happens is by your child participating in all of his/her scheduled sessions. Continued services with StarBright will depend upon understanding and adhering to the cancellation policy that is outlined below. All clients cancellations are reviewed on a regular basis and services may be subject to change based upon the number of cancellations that occur. It is also important that StarBright be able to document your child's progress to insurance companies. In order for optimal progress to occur all contracted sessions need to take place as scheduled.

Overall cancellation rate: If your overall cancellation rate (either monthly or year to date) exceeds 10% of your scheduled sessions for whatever reason, StarBright will meet with you to review your cancellations and see if current services are appropriate given the amount of cancellations and reasons for them. Based on your cancellation rate, your services may be reduced, terminated or transferred to another provider that is better able to meet your needs.

No Show/No Call: All families are expected to text/call cancellations to StarBright. If a family does not call in a cancellation and/or no is home when the staff arrives, StarBright will text/call to review the situation. If it happens a second time services are suspended or terminated.

If you are unable to keep your child's scheduled appointment you must notify StarBright that you are cancelling your session. StarBright recognizes 2 types of cancellations:

- Emergency/last minute cancellations: These are cancellations that occur within 72 hours of a scheduled appointment and are because of unavoidable reasons (sickness, accident, or similar event). Each family is allowed 1 last minute cancellation every 3 months.
- Advance cancellations: These are cancellations that are usually pre planned events such as vacations, doctor's appointments, holidays, or time off. These cancellations should be called in to StarBright as soon as the family knows about

the cancelled session. In these cases the earlier the better so that StarBright may be able to reschedule these sessions.

If you cancel a session, StarBright will attempt to provide you a make-up of that session based on staff availability. It may occur at a different time/day or with a different therapist but a slot will be offered to you. If you accept this make-up session, it will not be counted as a cancellation. If you are cancelling and then making up more than 10% of your scheduled session, StarBright will address this with you to work towards finding a more productive way to provide services for your child.

All staff are eligible for time off for vacation and illness. They will let you know in advance of any time off. StarBright will let you know of any last minute cancellation by staff. StarBright will make every attempt to reassign your cancelled slot to an open therapist and it is expected that you take that slot even though it may not be one of your usual therapists. StarBright will also try to reschedule that session whenever possible.

I have read, understand and agree to the terms and conditions of the StarBright cancellation policies

_____ _____

Parent/Guardian Signature Date

I have reviewed the StarBright cancellation policies with the parent/guardian and they have no questions or concerns and agree to follow the policies as outlined above

_____ _____

StarBright Representative Date

Allergy Form

Child's Name: _____ Date of Birth: _____

Please list any of your child's allergies and any medical conditions that your child may have.

Food:

_____

_____

Medications:

_____

_____

Any other substance that may cause an allergic reaction:

_____

_____

_____

If my child has an allergy, I authorize my child's name may be posted in the therapy rooms as a reminder to staff to prevent allergic reactions. This is very important to keep your child as safe as possible and involved in a healthy environment.

Parent's Signature: _____ Date: _____

Clinical Director's Signature: _____Date: _____

starBRiGHT
APPLIED BEHAVIOR ANALYST PLLC

Peanut/Tree Nut Free Facility Form

In an effort to maintain the safety for all our clients and staff, StarBright ABA has decided to become a nut free facility. We understand that nut allergies (Peanut and Tree Nut) are a major concern to parents with children between the ages of 2-5, as this is when most children will demonstrate their first allergic reaction. Therefore, to be able to maintain an environment that is safe for everyone, we are asking that no nut products be sent with your child to therapy sessions. Examples of nut products would be:

- Peanuts (raw peanuts, peanut butter, crackers containing peanut butter, and anything containing peanuts)
- Tree Nuts (examples include: almonds, pecans, cashews, pistachios, walnuts, pine nuts, macadamia nuts)

Upon arrival at your next session there will be a form for you to fill out. On this form you will be asked to indicate if your child currently has any allergies. Parents of a child with a food allergy must complete a food allergy plan which includes identification of the allergy, signs to watch for in case of reactions, and procedures to follow in case of a reaction. A copy of the plan (signed by the parents, therapists, and physician where applicable) will be kept in the child's file in the Clinical Director's office. Each student and/or staff member with a diagnosed food allergy must have a physician's authorization for any medication to be administered to help counteract any possible allergic reactions. Parents must provide the medication, with its original label, to StarBright ABA immediately.

If you have any questions about the new "Nut Free Policy" please contact me directly so that I can answer any questions you may have.

Sincerely,

Alisa Lanzetta
Clinical Director/Owner
StarBright Applied Behavior Analyst, PLLC

EMERGENCY MEDICAL AUTHORIZATION

I, _____ parent/guardian of _____, date of birth being_____, do hereby give permission to StarBright Applied Behavior Analyst PLLC, to secure and authorize such emergency medical care and/or treatment as above-named child might require while under the supervision of StarBright ABA. I further authorize StarBright ABA to administer emergency care/treatment as required, until medical assistance is available. I also agree to pay all costs and fees contingent of any emergency medical care and/or treatment for said child as secured or authorized under this consent.
NOTE: Every effort will be made to notify parents immediately in case of emergency. In the event of an emergency, it will be necessary to have the following information:

Child's Full Name_____ Child's Date of Birth_____

Child's Address_____ Home Phone _____

Mother's Work Phone_____ Father's Work Phone _____

Any known allergies or medical conditions of child:

_____

Medical Insurance Information:

Name of Company_____

Name of Member_____

Policy Number_____

Group Number_____

Phone Number_____

_____ Date_____
Parent/Guardian Print and Sign

_____ Date_____
Parent/Guardian Print and Sign

Client Email & Texting Informed Consent

Client Name: _____

The purpose of this consent is to review the option of receiving program information and any confidential protected health information (PHI) by email or text. Please review the following and ask any questions related to these two topics before consenting with your signature below.

Risk of using email/texting: The transmission of program information and/or your PHI by email and/or texting has a number of risks that you should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

- Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect emails sent through their company systems and potentially text messages sent through their company issued phone.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Email and texts can be used as evidence in court.
- Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and texts: Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct.

Clients/parents/legal Guardians must acknowledge and consent to the following conditions:

- Email and texting are not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.

- Email and texts should be brief/concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- All email may be printed and filed into the client's medical record. Texts may be printed and filed as well. This makes any information within the text or email a part of the client chart and will be discoverable upon audit, record request, subpoena, and/or court order.
- Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts outside of StarBright Applied Behavior Analyst PLLC without the client's/parent's/legal guardian's written consent, except as authorized by law.
- Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information. Provider is not liable for breaches of confidentiality caused by the client or any third party.
- It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Client Email & Texting Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between the Provider and me, and consent to the conditions and instructions outlined above, as well as any other instructions that the Provider may impose to communicate with clients by email or text (any specific instructions will be documented within the progress notes of your chart). Based on my understanding of the risks, I consent to the following (check all that apply):

_____ Email communications
_____ Text communications
_____ I do not wish to communicate via email or text

This consent will remain active until the time of discharge from program services or at the time the consent is revoked (whichever is earlier).

_____ _____
Client signature: Date:

_____ _____
Parent/Legal Guardian Printed Name and Signature Date:

_____ _____
Case Supervisor Printed Name and Signature Date:

starBRIGHT
APPLIED BEHAVIOR ANALYST PLLC

CLIENT DROP-OFF AND PICK-UP AUTHORIZATION

CHILD'S NAME:_____Today's Date:_____

Parent's Signature:_____

NO ONE WILL BE PERMITTED TO PICK UP YOUR CHILD IF THEIR NAME IS NOT LISTED BELOW. ALL PERSONS MUST SHOW THEIR PICTURE ID IF IT IS NOT ON FILE. MAKE SURE YOU LIST ALL ADULTS EVEN IF YOU RESIDE IN THE SAME HOUSEHOLD.

Parent/Guardian:_____
Cell Phone:_____ Work Phone _____Home Phone_____
Address_____City_____State_____

Parent/Guardian:_____
Cell Phone:_____ Work Phone _____Home Phone_____
Address_____City_____State_____

PERSON(S) OTHER THAN PARENT/GUARDIAN AUTHORIZED TO PICK UP YOUR CHILD

Name:_____

Cell Phone:_____ Work Phone _____Home Phone_____

Relationship: Grandparent Relative Friend Daycare Provider

Name:_____

Cell Phone:_____ Work Phone _____Home Phone_____

Relationship: Grandparent Relative Friend Daycare Provider

Name:_____

Cell Phone:_____ Work Phone _____Home Phone_____

Relationship: Grandparent Relative Friend Daycare Provider

Who Can Pick Up Your Child Only adults 18 years of age and older. In case of a last-minute change or addition, please send an email to the office with a signed and dated note authorizing your child's release to the new person and including the dates for which permission is given. Email authorization is accepted from a parent/guardian's email address that we already have on record. StarBright will not release clients to anyone, under any circumstance, other than those stated above. Anyone picking up students must carry a photo ID.

Parent's Guide to ABA Therapy

Authorization, Assessment, and Treatment

This guide has been provided to you to help you understand the process involved with starting applied behavior analysis (ABA) therapy with a Board Certified Behavior Analyst (BCBA). Please use this checklist to help you track the different events that occur. We look forward to serving your family!

Authorization - Before services start

- PCP sends the referral for ABA therapy to your provider
- Your provider will contact the insurance and verify benefits
- Your provider will contact you to set up an appointment for the assessment

What you can do during this time

- Wait to be contacted by the provider for an assessment to be scheduled
- Understand that the timeline varies by insurance company and can take up to 10 business days
- Be prepared for ideal times that you would like the assessment to occur
- Be prepared to set aside two hours for the assessment
- Be prepared with questions to ask the BCBA
- Be prepared to discuss what you are wanting out of ABA therapy. If you are unsure, your BCBA will provide you with guidance.

Assessment - Beginning the process to determine what treatment will look like

- A BCBA will meet with you and your child

Please make the following records available for review:

- Diagnostic report
- Any previous ABA treatment plans from other providers available
- IEP, ARD, or 504 plan

You will sing a form indicating that you consent to an assessment

The assessment will include the following components:

- Parent/caregiver interview

- Administration of assessment (e.g. forms for you to fill out)
- Observations of your child
- Interaction with your child
- Documentation of your child's behavior

The BCBA will schedule a time with you to review the assessment results prior to submitting to the insurance for approval

What you can do during the assessment phase:

- Understand the writing process will take up to two weeks
- Understand that the timeline varies by insurance company but approval of a plan may take 10-15 business days.
- Be prepared to review the assessment results and treatment plan with the BCBA.
- Know that the assessment writing will be reflected on your Explanation of Benefits (EOB) from your insurance company expresses as codes and on dates that you may not have seen the BCBA.
- Understand that your child may not get all hours requested authorized by the insurance company. If so, your BCBA will contact you and discuss how to proceed.

Treatment - Services have begun

- The BCBA and Behavior Technicians will be providing therapy through supervision and direct interaction. Your child's progress will be recorded through data collection and documentation.
- Your signature will be required on the session note/timesheet at the end of each session.
- You will participate in parent training on strategies and interventions used in therapies.
- The BCBA will report on both child and parent progress at the end of the authorization period.

What can you do during the treatment phase:

- Ask the BCBA and Behavior Technicians questions when you have them.
- Make sure to participate in parent training when they are scheduled. These are very important to the success of your child's treatment.
- Understand that treatment services will be reflected on you EOB.
- Ask your provider about any questions that you have about dates of services.
- Know that any changes made to your child's treatment will not be done without your foreknowledge or written consent.

INFORMED CONSENT FOR ABA (Applied Behavior Analysis) SERVICES

I, _____, as a parent or guardian, give my consent for StarBright ABA to provide behavior analytic services to my child _____, in accordance with the ethical guidelines proposed by the Behavior Analysis Certification Board (BACB) and New York State law. I also understand that I may withdraw my consent and terminate treatment at any time for any reason.

I understand that StarBright ABA does not diagnose, but that StarBright ABA provides behavior analysis to individuals diagnosed with autism, autism spectrum disorders, and related disorders.

I understand that any information provided in this intake, as well as any information obtained at any point during the interview process or course of treatment, is kept strictly confidential in accordance with HIPAA regulation guidelines and the law. I understand that state laws may require that confidentiality be broken under circumstances, specifically, if I am judged by the Board Certified behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected child abuse.

I understand that the StarBright ABA staff will use behavior modification principles, concepts and other methodologies to allow my/our child to learn strategies and approaches. I understand that the individualized program will be designed to maximize my child's success. Methodologies and procedures used will include, but will not be limited to: discrete trials, verbal behavior, natural environment training, prompts, and rewards for correct responses. All procedures will be described and demonstrated at the request of the guardian. A copy of my child's treatment plan(s) is available upon request.

I understand that Board Certified Behavior Analysts are bound to strict ethical guidelines of practice and that any issues of concern that may arise throughout the treatment process that are out of the behavior analyst's area of experience may result in referrals to a more appropriate agency or individual.

I understand that for the maximum benefit to my child, my/our participation is essential. I will be notified of all interventions implemented for my child and that they are subject to my approval. Furthermore, I understand that I will be given a document outlining any procedures used. I understand that I am expected to (a) attend all meetings concerning my/our child, and (b) practice therapy procedures that are taught to me/us by the StarBright ABA staff so that

my/our child's skills will generalize more easily. Furthermore, I understand that if I do not attend meetings and generalize procedures at home my child's progress may be limited.

I understand that the behavioral techniques used may not necessarily produce observable results during the course of time in which my/our child receives services. The subsequent short- and long-term applications of these techniques have proven to be beneficial for other children with developmental disabilities and the StarBright ABA staff expects similar results for my child. I understand however, that my child may or may not benefit. In addition, my child may experience behavioral difficulties during and following the ABA program and I understand that all efforts will be made to prevent, eliminate, and minimize such negative effects of participation. I understand that StarBright ABA does not and cannot guarantee outcomes from the services provided.

_____	_____
Signature	Date
_____	_____
Printed Name	Name of Client

Coordination of Care between Behavioral Health and Primary Care Providers

Integrated care is the best practice model that addresses the whole health of an individual. While full integration is not always possible, behavioral health providers (BHPs) have the opportunity to improve coordination of care across disciplines by collaborating with clients and increasing outreach to primary care providers (PCPs), related service providers in a school setting, private setting, and other former or current behavioral/mental health consultants (if applicable). Through this collaboration, StarBright ABA can improve the safety and efficacy of services to support better outcomes for clients.

What concrete steps does StarBright ABA take to better partner with clients and overcome barriers to care coordination?

- Speak with new clients about the advantages of coordination of care between BHPs and PCPs.
- Ask the client to sign an authorization to exchange information with the member's PCP.
- StarBright will update the authorization document annually or as the member's needs or preferences change.
- Help the client find a PCP if the client does not identify one.
- Ask about the clients concerns.
- Assess the client's understanding of his or her medical conditions and how they may interact with behavioral health issues.
- Give a copy of a treatment summary to the client to share with the PCP or other providers.

What can BHPs do to develop relationships with PCPs, and related service providers to improve care coordination?

- Reach out to the PCP office, briefly explain the advantages of coordinating care, and ask how your offices might exchange information most easily to better serve the client.
- For complex cases, StarBright will consider a personal call to the PCP office to discuss the case. Include consultation regarding any current or historical adverse medication reactions.

How can BHPs build or enhance standard procedures for care coordination within their agencies?

- Establish communication with the PCP as a routine part of service provision and documentation at service initiation, at discharge, and after significant changes in treatment occur. Integrate communication with the PCP into Individual Service Plans.

Coordination of Care Form

Please complete the form to inform or seek information from another provider.

CLIENT INFORMATION:

Client Name: _____ Client DOB:_____

Member/Client Identification Number: _____

PROVIDER INFORMATION:

Name of Provider:_____

Address:_____

Telephone Number:_____ Fax Number:

_____

CLINICAL INFORMATION:

Treatment Date (s):_____ Next Appointment Date:_____

Diagnosis/Medications:

Presenting Symptoms:

Treatment Plan/Recommendations:

Additional Comments:

_____ _____

Providers Signature Date

Appropriate, signed release of information form is on file.