starBRIGHT
APPLIED BEHAVIOR ANALYST PLLC

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ABA Program Intake Packet

Thank you for selecting StarBright ABA to help you meet the needs of your child. We know you have many options to choose from and appreciate you selecting us to assist you with this important process.

The attached packet of information will help inform you about StarBright ABA's policies and procedures, and allow you time to gather information prior to your intake appointment.

Thank you for the trust that you are placing in us to assist you and your family. We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information we have the better we will be able to assist you and your family. If at any time in this process you have questions please contact us.

We look forward to meeting you and your child.

Applied Behavior Analysis (ABA) Program

What is ABA?

Applied Behavior Analysis (ABA) is an evidence-based approach to creating meaningful or socially significant behavior change. New skills and behaviors are taught while any problem behaviors are minimized. ABA focuses on behaviors that are observable and measurable, with respect to their antecedents and consequences, which are events that occur directly before and after the behavior of interest. This approach utilizes principles of reinforcement, which typically involves providing rewards to increase skills that are functional and socially significant throughout the child's daily life (as noted below). ABA not only teaches these skills, but also promotes maintenance and generalization of the skills. Maintenance is used to determine whether or not the child can still perform the skill after a given amount of time has passed. Generalization requires that the child not only learns a particular skill in a structured 1:1 teaching environment, but ensures that the skill transfers to different people, materials, instructions, and environments. ABA also serves to decrease behaviors that may interfere with learning, such as tantrums, aggression, or stereotypy (hand flapping, spinning, etc.). Individualized curricula are developed to facilitate learning and develop appropriate programming for each child. Areas that we work on include (but are not limited to):

Language and Functional Communication: Communicating needs/wants to others
Independent Play: Playing alone without assistance
Social Skills: Interacting with others
Imitation: Imitating behaviors or vocalizations of others
Gross/Fine Motor Skills: Control over balance and body movement
Listener Responding: Attending and responding to spoken words
Visual/Perceptual Skills: Interpreting things he/she sees visually
Self-help Skills: Skills such as dressing, grooming, feeding, toilet training

STARBRIGHT ABA Policies and Procedures

1. For initial assessments, STARBRIGHT ABA reserves the right to discontinue services or return a client to the wait list if the guardian does not inform the Board Certified Behavior Analyst (BCBA) of the cancellation within 24 hours of the scheduled assessment.

2. If a child is sick, the session should be cancelled. Staff will not work with a child who has any contagious illness (vomiting and/or diarrhea within the past 24 hours, infection, rash, fever, etc.). Your child must be fever free for 24 hours without the aid of medication. If a staff member notes any of these symptoms, the session will be cancelled for that day.

3. Please alert STARBRIGHT ABA staff prior to the start time if the child will be late for the assigned session or will be missing the session out of courtesy. If your child will be missing a significant portion of the session the session may be cancelled at the discretion of the BCBA. Sessions that start late will end at their scheduled time and will not be extended to complete the full scheduled duration.

4. Parents need to arrive at least 10 minutes before the end of the scheduled session to talk with the Implementer about the session and any other programming information. Late pick-ups may delay the start of another session and STARBRIGHT ABA staff must be notified if a parent will be arriving late. If the child is late being picked up by the parent the additional time will still be billed.

5. If there are 3 consecutive cancellations/late arrivals, or 3 cancellations/late arrivals within 1 month, then treatment continuation will be reviewed by the BCBA. It will then be determined if transition and discharge from STARBRIGHT ABA will occur. Consistent attendance for sessions is important for progress toward treatment goals. Lapse in treatment attendance inhibits the progress of therapy.

6. Sessions cancelled 24 hours or more in advance may be able to be rescheduled. However, this needs to be done in accordance with the clinic and staff schedule. The BCBA will determine if/when the hours can be made up.

7. STARBRIGHT ABA encourages staff to continue with professional development. STARBRIGHT ABA may hold in-service days and/or staff meetings for professional development. During such, implementers do not provide treatment.

8. Program modifications shall be made through the BCBA in consultation with a Licensed Behavior Analyst. If guardians or implementers have changes that need to be made, this should be discussed with the BCBA. If it is urgent, the clinical director should be called immediately.

9. STARBRIGHT ABA policy is to avoid dual relationships between clients (including their families) and staff. Please do not ask our staff to engage in tasks/activities outside of their STARBRIGHT ABA role/responsibilities (i.e., babysitting, attending birthday parties or other events, giving/receiving gifts, privately paying for ABA services outside of STARBRIGHT ABA, etc.).

10. Confidentiality is important. Please do not discuss any known information about other children or families receiving services through STARBRIGHT ABA to others outside of the facility.

11. STARBRIGHT ABA will attempt to keep consistent staff with each client; however, this will vary across services with the child. Some reasons include scheduling changes, promotions, illness, etc. This may benefit the child in that it allows him/her to work on generalizing learned skills to other staff.

12. In the event of inclement weather, we will make every effort to provide services. However, there may be hazardous conditions that result in the cancellation of a session. A decision will be made by the BCBA to reschedule the session.

13. For a center-based program to be most effective, it is essential that the guardian/caregiver implement the strategies outside of the session. To facilitate the child's progress, the BCBA will make recommendations, parent goals, and staff will provide parent education.

14. Due to the nature of STARBRIGHT ABA services, parent education is essential. The BCBA reserves the right to discontinue services if recommendations are not being carried over in the home setting (e.g., behavior intervention plan, data collection, etc.) by the child's parent/guardian.

15. STARBRIGHT ABA encourages collaboration with other service providers. Third party observations are permitted one time on a quarterly basis for a maximum of 30 minutes, unless otherwise specified by the BCBA. Proper release forms must be on file before an observation is scheduled.

16. All STARBRIGHT ABA staff members are mandated reporters. If any staff believes there is any cause to suspect abuse and/or neglect, the local Child Welfare Department reporting procedure must be followed. STARBRIGHT ABA staff members are not responsible for the outcome of the investigation.

____

Initial / Date

Referral, Diagnosis Evaluation, and Insurance Form

The following information must be completed and returned as a part of the intake process for ABA services. These are required for billing and insurance authorization purposes. Any incomplete sections will slow down the intake process and may cause delays in the start of services.

Please read and initial next to each statement. All steps must have been completed for the ABA Intake Process to be completed.

_____ Each patient must have an assigned primary care physician (PCP). Contact your insurance provider to get a PCP assigned if your child does not already have one assigned.

_____ The patient must have proof of an Autism Spectrum Disorder diagnosis written by a medical doctor (MD).

Patient Name:____

Parent/Guardian(s)Name:____

Primary Care Physician (PCP) :____

Phone: ____________________________

Fax:______________________________

PCP Address:____

Diagnosis Clinic/Doctor:____

Diagnosis:____

Name of Insurance:____

Subscriber's Name on
Card:____

Member ID Number: _____________________________

Group Number:______________________________

Active from: ____/____/_______ Active to: ____/____/_______

Subscriber's Name: _____________________________________

Subscriber's Birthday: _____________________________________

Subscriber's Place of Employment: _______________________________

Subscriber's Relationship to Child:_______________________________

Insurance Phone Number: ________________________________

Pre-authorization phone number for Mental Health:_____________________________

CONFIDENTIAL

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding you child. The Early Intervention Center will hold information provided by you is strictly confidential and will only be released in accordance with HIPAA guidelines and as mandated by law. Please use the backs of the pages for additional information.

PLEASE PRINT

Name of the Person Completing this form:

____

Legal Name of the
Child:____

Nickname or name child routinely goes by:

____

Child's Date of Birth: ______________ Age: __________ Male Female

Home Address: ____
Street

____
City County State Zip

Home Telephone Number: ____-____-_______

Work Phone(s) Mother: ____-____-_______ Father: ____-____-_______

Cellular Phone(s) Mother: _______-________-____________

Father: _______-________-____________

Preferred Method of Contact Mother: Home Cell Work

Father: Home Cell Work

Are parents _______married _______divorced _______ separated? If divorced, who has custody of minor? __________________________ If divorced, please provide a copy of the custody agreement.

If divorced, how long have the biological parents been divorced? ______________

Please list the name(s) of the stepparents: ________________________________

Is there a birth parent living outside the home: (circle one) MOTHER FATHER

Name: _______________________ Where do they live? _______________________

If birth parent(s) do not live in the child's home, how much contact does the child have with the parent not having custody, with step siblings, etc.?

____

____

SIBLINGS

Name:	Age:	DOB:	Grade:
Name:	Age:	DOB:	Grade:
Name:	Age:	DOB:	Grade:
Name:	Age:	DOB:	Grade:
Name:	Age:	DOB:	Grade:

Please indicate any special needs or concerns regarding the other children living in your home:

____

____

____

____

Please indicate any concerns you have regarding the child for whom you are seeking services and these siblings' relationship(s):

____

____

____

____

Others: List any other people who currently live in your home?

Name	Age	Relationship to Child	Years Living in Home
1. ______________________	_____	________________________	From_____ To_____
2. ______________________	_____	________________________	From_____ To_____
3. ______________________	_____	________________________	From_____ To_____
4. ______________________	_____	________________________	From_____ To_____
5. ______________________	_____	________________________	From_____ To_____

Are there any other people who have a significant role on how this child is raised?

____

FAMILY PSYCHOLOGICAL HISTORY:

Is there a history in your immediate or in the mother's or father's extended family, of the following, and if so who?

Yes	No		Who
____	____	Autism Spectrum Disorders	____________________________
____	____	Learning Problem/Disabilities	____________________________
____	____	ADHD – ADD – Attention Problems	____________________________
____	____	Depression & Manic Depression	____________________________
____	____	Behavior Problems in School	____________________________
____	____	Anxiety Disorders (OCD, Phobias, etc)	____________________________
____	____	Cognitive Impairment	____________________________
____	____	Psychosis/Schizophrenia	____________________________
____	____	Substance Abuse/Dependence	____________________________
____	____	Other Mental Health Concern (please list)	____________________________

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child:

____

____

____

____
____

Please provide us a brief account of your pregnancy and delivery.

____
____
____
____
____

DEVELOPMENTAL HISTORY

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

• Rolled over consistently ____________

• Sat up unsupported ____________

• Stood ____________

• Crawled ____________

• Walked unassisted ____________

• Said 1 st 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 ____________

2. Please indicate if your child is experiencing any of the following: (if so please comment)

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 ____

Fatigue/tiredness during the day ____

Nightmares ____

Bed wetting ____

Soiling ____

Problems with authority ____

Anxiety ____

Unmotivated ____

Stress from conflict between parents ____

Legal situation (anyone in the family) ____

History of abuse ____

Alcohol/drug use/abuse ____

School concentration difficulties ____

Grades dropping or consistently low ____

Sadness or Depression ____

3. List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

____

____

____

____

____

4. Child's current height: ______Ft. ______Inches Weight: ______Lbs.

5. With which hand does the child write? _______________

6. Does the individual have any vision problems? ____________________

Please list date of last vision test and who performed (pediatrician, optometrist & school)

____

____

____

7. Does the child have any hearing problems? __________________________________

Please list date of last hearing test and who performed (pediatrician, audiologist & school)

____
____
____

8. Name of child's primary physician(s):

____

Practice Name:

____

Address:

____
____

Phone Number: _________________________ Fax Number: _____________________

(Please list information on additional Physicians on the back of the page)

Describe your child's daily routine (including times to wake up, naps, bedtime, meals, school, etc)

Morning

Afternoon

Early Evening

Night

GENERAL INFORMATION:

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Like Child to do More Often	Like Child to do Less Often
1. ______________________________	_______________________________
2. ______________________________	_______________________________

3. ________________________________ ________________________________

4. ________________________________ ________________________________

5. ________________________________ ________________________________

MEDICATIONS:

Please list any medications that your child is currently taking:

Medication Name	Dosage	Length of Time Taken
_________________	___________	__________________
_________________	___________	__________________
_________________	___________	__________________
_________________	___________	__________________

Please list any supplements, vitamins, etc. that your child is currently taking:

Medication Name	Dosage	Length of Time Taken
_________________	___________	__________________
_________________	___________	__________________
_________________	___________	__________________

PSYCHOLOGICAL/MEDICAL TESTING: Please list any psychological/medical testing that your child has completed:

Test Name	Month/Year	Results
_________________	_____________	__________________
_________________	_____________	__________________
_________________	_____________	__________________

CURRENT MEDICAL CONDITIONS

Please list any medical diagnosis: Cerebral Palsy Autism/PDD ADHD MR Hyperactivity ADHD (Short attention span) Physical/Speech delay

Vision/Hearing impairments ODD (Noncompliance)

Other:

Please list any current allergies that your child may have:

Please list any special nutritional needs:

Are immunizations up to date? Attach a copy of the child's immunization records:

CURRENT TREATING PHYSICIANS

Doctor's Name:	Doctor's Name:
Specialty:	Specialty:
Address:	Address:
Phone Number:	Phone Number:

Pertinent Information

Please state your child's behaviors of concern: ____
____
____
____

Please state the expectations/goals that you have for child while engaging in a behavioral program:
____
____
____

Please list any other information that may be helpful while assessing and/or conducting therapy with your child:
____
____

Please describe the problems your child is now having and what type of services you are seeking from us to address these problems. Please use the back of this sheet for addition space.
____
____
____

SKILLS ASSESSMENT

LANGUAGE:

Does your child..... Comments

Match objects or pictures? yes no

Imitate actions of others? yes no

Follow directions without visual cues? yes no

Indicate his/her needs or wants? yes no Circle one: words pictures gestures

Imitate sounds or words when modeled? yes no

Use words to ask for things? yes no

Label items he or she sees or hears? yes no

Answer questions? yes no

Speak in sentences? (if no, skip remaining questions) yes no If yes, average length? 3 5 8+ words

Participate in conversations? yes no

What are your principal concerns regarding your child's language?

PLAY SKILLS

Does your child..... Comments

Look at books? yes no

Play with cause/effect toys (i.e.: Jack in the Box)? yes no

Complete task completion toys (i.e.: puzzles, beads)? yes no

Play with toys by using them like real items (i.e. uses a play spoon to pretend to eat)? yes no

Play simple games like ring around the rosy? yes no

Construct items using blocks, legos, or other items? yes no

Play games with rules (i.e.; memory)? yes no

Engage in dress up or role play (i.e.; pretending to be a chef?) yes no

Play appropriately on his or her own for up to 5 minutes? yes no

What are your principal concerns regarding your child's play skills?

SOCIAL SKILLS

Does your child….. Comments

Respond to his or her name by looking at you? yes no

Make eye contact when speaking to you? yes no

Greet you when you arrive home? yes no

Respond to others emotions? yes no

Attempt to involve you in something that he/she is doing to share interest (not b/c he or she needs your help)? yes no

Observe other children playing? yes no

Join in with other children when they are playing? yes no

Take turns in games? yes no

Verbally interact with peers? yes no

What are your principal concerns regarding your child's social skills?

SELF HELP SKILLS

Does your child….. Comments

Sleep through the night? yes no

Sleep in his/her own bed without supervision? yes no

Drink from a cup? yes no

Eat a variety of foods (i.e. fruits, veggies, meats, grains)? yes no

Use a spoon and a fork to feed himself or herself? yes no

Remove pull-down garments independently? yes no

Remove socks and shoes independently? yes no

Remove shirts independently? yes no

Put on pull-up garments independently? yes no

Put on socks and shoes Independently? yes no

Put on shirts Independently? yes no

Use the toilet independently? yes no

What are your principal concerns regarding your child's self help skills?

FINE MOTOR

Does your child….. Comments

Unwrap presents? yes no

Pour water or sand from one object to another? yes no

Turn doorknobs to open doors? yes no

Use one hand consistently? yes no

Use a crayon with hand NOT fisted? yes no

Copy lines and simple shapes? yes no

Write his or her own name? yes no

Use scissors? yes no

What are your principal concerns regarding your child's fine motor skills?

GROSS MOTOR

Does your child….. Comments

Walk up and down stairs with alternating feet? yes no

Walk around or step over items that are on the floor? yes no

Jump off the ground with both feet? yes no

Kick a playground ball to you? yes no

Throw a playground ball to you? yes no

Catch a ball when thrown? yes no

Show interest in sports? yes no

What are your principal concerns regarding your child's gross motor skills?

ACADEMIC SKILLS

Does your child..... Comments

Identify shapes? yes no

Identify colors? yes no

Identify numbers? Yes no

ACADEMIC SKILLS cont'd

Does your child..... Comments

Identify letters? yes no

Identify locations, occupations, and functions of objects (i.e.; the refrigerator keeps things cold) yes no

Use pronouns, plurals and prepositions appropriately? yes no

Identify cause/effect relationships? yes no

What are your principal concerns regarding your child's academic skills?

CHALLENGING BEHAVIORS Please list any challenging behaviors that your child may exhibit and complete the table accordingly.

Types of Behavior	Please describe the behavior, ie: what does it look/sound like?	What typically happens immediately before, or triggers the behavior?	How many times per day or week does this behavior occur? If the behavior lasts for more than 10 seconds, list the average duration of the behavior	What typically happens after the behavior, or, what do you do when this behavior occurs?
Tantrums				
Failure to follow directives				
Aggression				
Running away				
Self injurious behaviors				
Eats inedible objects				
Other				

SELF STIMULATORY BEHAVIORS

Please list any self stimulatory/repetitive behaviors that your child may exhibit and complete the table.

Types of Behavior	Please describe the behavior, ie: what does it look/sound like?	What typically happens immediately before, or triggers the behavior?	How many times per day or week does this behavior occur? If the behavior lasts for more than 10 seconds, list the average duration of the behavior	What typically happens after the behavior, or, what do you do when this behavior occurs?
Vocal (repeating vocalizations, words or phrases)				
Preoccupations with items, topics, etc.				
Repetitive motor mannerisms (hand flapping, spinning items, lining up objects, etc.)				
Routine behaviors (insisting on the same cup, same route in the car)				

WHAT ARE THINGS THE PERSON LIKES AND ARE REINFORCING FOR HIM OR HER?

Food Items: ____

____

Toys and Object:____

____

Activities at Home: ____

____

Activities / outings in the community: _______________________________________

____

Other:____

TREATMENT HISTORY Please list any treatments that your child has received in the past to the best of your ability.

Type of Treatment	Service Provider or Clinician And Contact Information	How many hours per week was this treatment provided?	Dates of Treatment	Did you feel that this treatment was beneficial? Please explain
Special Education Classroom			Start Date: End Date:	
Speech Therapy			Start Date: End Date:	
Occupational Therapy			Start Date: End Date:	
Physical Therapy			Start Date: End Date:	
Other ABA Program			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	

CURRENT TREATMENT AND SCHEDULE

Please list any treatments that your child is currently receiving and complete the table.

Type of Treatment	Service Provider or Clinician And Contact Information	How many hours per week is this treatment provided?	Start Date of Treatment	Do you feel that this treatment is beneficial? Please explain
Regular Education Classroom			Start Date:	
Special Education Placement			Start Date:	
Speech Therapy			Start Date:	
Occupational Therapy			Start Date:	
Physical Therapy			Start Date:	
Other ABA Program			Start Date:	
Other:			Start Date:	
Other:			Start Date:	

Please complete the schedule to indicate your child's availability.

Sunday	Monday	Tuesday	Wednesda y	Thursday	Friday	Saturday

Please list the five behaviors you would like for our child to do more of and less of in order of priority to your family.

Behaviors to Increase	Behaviors to Decrease
1. __________________________	____________________________
2. __________________________	____________________________
3. __________________________	____________________________
4. __________________________	____________________________
5. __________________________	____________________________

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 anytime 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

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

SERVICES OFFERED: We will provide services specifically designed to help you and/or your minor child, or otherwise provide you with referrals to other professionals. Our behavioral services consist primarily of individual behavioral and skill assessments and short and long-term ABA service provision to youth in the autism spectrum.

APPOINTMENTS: Except for rare emergencies, we will see your child at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitates the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you give us as much notice as possible. This will allow us to offer your time to another person. You will be charged a $40 hourly rate (Example: 2 hour session = $80 cancellation fee) Additionally, please note that insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

PREPARATION FOR TESTING: It is important that individuals be able to perform at their best during testing sessions. Please let us know before we arrive (and as soon as possible) if the individual to be tested is not feeling well, or is taking any prescribed or over-the-counter medications that we have not been told in advance. In such cases, the testing session may need to be rescheduled. Individuals to be tested should be well rested and should have snacks for breaks during the testing session. Because of the variety of dietary restrictions we do not offer any food or snacks.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION: Behavioral 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 specific

information to specific individuals, or under other conditions and as mandated by New York and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

TO PROTECT THE CLIENT OR OTHERS FROM HARM: If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, an intended victim, a minor's parents, or others who could provide protection, or seek 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 to them. Unless you object, we do not typically tell clients about these consultations; however these consultations will be so noted in your Private Health Information. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

RECORDS: We will review all testing results during our feedback session, and offer you opportunities to ask questions and discuss the results with us. You will receive a written report that summarizes the findings. This report will include a summary and interpretation of all individual testing, as well as impressions from individual observations and consultations conducted as a part of a comprehensive individual evaluation. Upon your request, we are happy to provide you with a written summary of our impressions from other meetings, consultations, or observations as well. We will forward copies of any reports or written summaries to others only with specific, written consent from you, or as allowed under the law. Because of the proprietary nature of testing and program materials, we will release raw testing data only to other appropriately credentialed professionals (except as otherwise required by law).

PAYMENT FOR SERVICES: If necessary, we may seek assistance from an outside party in order to collect payment for services rendered to you. In such cases, any disclosures are limited to the minimum that is necessary to achieve the purpose. As you might suspect, the laws and professional standards governing these issues are quite complex, and it is important that we discuss any questions or concerns that you or your minor child may have at our first meeting, and as they may arise in the course of our work together. If any of these types of situations arise, we will make every effort to fully discuss it with you before taking any action, and we will limit disclosure to what is necessary. We are not attorneys, however, and you may wish to obtain formal legal consultation if you need specific advice.

HEALTH CARE INSURANCE: If we do not file your insurance claims, we will provide you with statements that you may submit to your insurance carrier or complete any forms as required by

your insurance carrier in order to obtain reimbursement for out-of-network providers. In order to assist you with obtaining reimbursement for our services, your insurance carrier may require that we provide clinical information such as treatment plans or summaries or copies of your child's entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you and your child that is necessary for the purpose requested. This information will become part of the insurance company's files and will probably be stored in a computer. Although all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report or form that we submit upon your request. By signing this Agreement, you agree that we can provide requested information to your carrier if/when you choose to file a claim for any services that we have provided to you or your child.

PROFESSIONAL RECORDS: You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in two sets of professional records. One set contains the Clinical Record and the other professional's personal notes. 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. Except in unusual circumstances that involve danger to yourself or others, or makes reference to another person (unless such other person is a health care provider) and we believe that access is reasonably likely to cause substantial harm to such other person, you or your legal representative may examine and/or receive a copy of your Clinical Record, if you request it in writing because the professional's personal notes are professional records, they can be misinterpreted and/or upsetting to untrained readers, or may contain information that is protected by federal copyright laws. For this reason, we recommend that you initially review them in the presence of one of our Licensed Behavior Analysts, or have them forwarded to another mental health professional so that you can discuss the contents. In most cases we are allowed to charge a fee for coping (and for certain other expenses) plus postage. The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your records, you have a right of review (except for information provided to us confidentially by others), which we will discuss with you upon request. In addition, we also keep a set of Personal Notes for most clients to whom we provide even brief or consultative services. These notes are for the personal use of the professional alone and are designed to assist in providing you with the best treatment. While the contents of Personal Notes vary from client to client, they can include references to conversations, testing recording forms, analysis from conversations, hypotheses of the professional, and the effects of these conversations on clients. They also may contain particularly sensitive information revealed that is not required to be included in the Clinical Record. Personal Notes are not available to you and

cannot be sent to anyone else, including insurance companies. 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. StarBright expressly reserves the right to the fullest extent permitted by law to refuse access to records.

CLIENT RIGHTS: HIPAA provides you with certain rights with regards to your Clinical Record and disclosures of protected health information. These rights include requesting that 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 that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make 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.

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 some times when you will be available. Because of the nature of the services we provide, we do not provide on-call coverage 24 hours per day, 7 days per week. In emergency or crisis situations please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

INDEMNIFICATION: To the fullest extent permitted by law and except to the extent caused by the negligence of StarBright Applied Behavior Analyst PLLC. Parent shall indemnify, defend and hold StarBright Applied Behavior Analyst PLLC, its trustees, members, principals, partners, officers, directors, employees, and agents ("Related Parties") harmless and shall indemnify StarBright Applied Behavior Analyst PLLC and Related Parties against and from all liabilities, obligations, damages, penalties, claims, actions, costs, charges, and expenses, including without limitation, reasonable attorneys' fees and other professional fees (if and to the extent permitted by law), which may be imposed upon, incurred by or asserted against StarBright Applied Behavior Analyst, PLLC or any of the Related Parties and arising out of or in connection with any damage or injury arising out of StarBright Applied Behavior Analyst PLLC providing applied behavior services in an office setting or through home based services to ________________________("Child") or arising out of any acts or omissions (including violation of Law) of Parent or Child.

CONSENT: Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

________________________________	______________
Client/Child’s Name	Date
________________________________	__________________________
Parent/Guardian #1 Name	Parent/Guardian #2 Name
________________________________	___________________________
Parent/Guardian #1 Signature	Parent/Guardian #2 Signature

Patient Confidentiality Contact Form

Patient confidentiality is a top priority at StarBright ABA. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.

In the event that I, ______________________________________, am unable to be reached, StarBright ABA may leave information with the following:

____________ Other adult in household (Name): _____________________________________

____________ On home answering machine (#): ______________________________________

____________ On cell phone (#):____

____________ I may be reached at my work number:__________________________________

____________ May leave a message at work on my voicemail:__________________________

____________ Other (please describe): ____

OPT OUT (initials) ___________ in the event that I am unable to be reached, StarBright ABA **MAY NOT** leave information with anyone but myself**. I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff at StarBright ABA**.

Patient's Signature:____ Date: _______________

Parent's Signature: ____ Date:_______________

Request/Authorization to Release Confidential Medical & Mental Health Records and Information

Source of Information

Person or facility: ____
Address: ____
Phone Number: __________________

Identifying Information

Name: ____
Address: ____
____
Phone: _______________________ DOB: ____________ Social Security #: _________________
Parent/Guardian: ____

Address:____
____Phone Number: __________________
I hereby authorize the source named above to send, as promptly as possible, the records marked below to StarBright ABA at 118 River Road, Suite 14 Harriman, NY 10926. (The items not to be released have a line drawn through them.)

Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness:

Date(s) of inpatient admission: ______________ Date(s) of discharge: _________________

Start of outpatient treatment: _______________ End of treatment: ___________________
Clinical/Client #: _______

Other identifying information about the service(s) rendered:____________________________
Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the client.

Psychiatric evaluations, reports, or treatment notes
Treatment plans, recovery plans, aftercare plans
Admission and discharge summaries
Social histories, assessments with diagnosis, prognosis, recommendations, and all similar documents
Information about how the client's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work
Workshop reports and other vocational evaluations and reports
Billing records
Academic or educational reports
Report of teachers'/staff observations
Achievement and other tests results

A letter containing dates of treatment(s) and a summary of progress
Other: ____

I further authorize the source named above to speak by telephone with staff of StarBright ABA about the reasons for my/the client's referral, and relevant history or diagnosis, and other similar information that can assist with my/the client's receiving treatment or being evaluated or referred elsewhere.

I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan. The information disclosed may be used in connection with my/the clients treatment.

In consideration of this consent, I hereby release the source of the records from any and all liability arising there from.

This request/authorization is valid during the pendency of any claim or demand made by or on behalf of me/the client and arising out of an accident, injury, or occurrence to me/the client. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 365 days from the date I sign it.

I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releasor, and a witness if necessary.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

_________________________________ _______________________________ ______

Signature Printed Name Date

_________________________________ _______________________________ _______

Signature of parent/guardian/representative Printed Name Date

Rules & Regulations

Absences, Vacations & Holidays (Center and Home Based Services)

1. I/We understand that in the event of inclement weather, all StarBright ABA programs will follow the local public school's procedures. A two/three hour delay will result in the office opening at___________ I/We further understand that the clinical director has the discretion to close the center due to exigent circumstances if needed even if the public schools have not closed.

2. I/We understand that if the center location is closed, StarBright ABA main administration office will also be closed.

3. StarBright ABA has scheduled in-service and vacation breaks. I/We understand that I/we will be provided with a calendar of those scheduled breaks in advance.

4. If you are privately paying for StarBright ABA services, in the event of an emergency StarBright ABA is likely to incur up to three (3) emergency closures per calendar year and that I/we will not be reimbursed or credited tuition for those closures. I/We also understand that if circumstances arise that the center is forced to close more than three (3) times during the calendar year, I/We will be credited a prorated amount on the next months tuition statement. Emergency closures include, but are not limited to, power outages, snow/ice storm, building problems such as a water main break, etc.

5. I/We understand that requests for leaves of absence or extended vacation from the program must be submitted with at least 30 days notice and will be reviewed by the Director. Upon approval arrangements will be made on a case by case basis.

Illness Policy

6. I/We understand that if my child's temperature is at or above 100° I/we will be contacted and that my/our child will be required to be picked up. I/We further understand that in the interim of my arrival, my/our child will be quarantined from the other children by being placed in the main office with a staff member.

7. I/We understand that my child must be fever free for a minimum of 24 hours before returning to the center, without the aid of any fever reducing substance. I/We further understand that administering medicine such as Tylenol to reduce my/our child's fever so that he/she can return to the center is not permitted and grounds for dismissal from the program.

8. I/We understand that I/we will be called to pick up my child if he/she has two (2) or more unexpected instances of diarrhea in one (1) day. I/We further understand that this does not apply to children that have chronic or dietary issues that may cause excessive diarrhea when those issues have been previously discussed with the clinical director. I/We understand that

my/our child will not be permitted to come back to the center until 24 hours have passed with no diarrhea instances.

9. I/We understand that I/we will be called to pick up my/our child if he/she has one (1) or more instances of vomiting. I/We further understand that this does not apply to self-induced vomiting. I/We understand that my/our child will not be permitted to come back to the center until 24 hours have passed with no instances of vomiting.

10. I/We understand that I/we may bring my/our child to the center if he/she has a common cold (slight occasional cough, clear runny nose, occasional sneezing). I/we further understand that if my/our child has discharge of any other color than clear, my/our child will be sent home. I/We also understand that if my/our child has a constant running nose which needs to be wiped continually, regardless of the color, he/she will not be permitted to stay at the center. I/We understand that if my/our child has a runny nose which lasts for more than one (1) week in which I/we suspect is due to allergies, I/we will be required to bring a doctor's note to the clinical director stating this fact.

11. I/We understand that if my/our child has any rash other than a mild diaper rash I/we must bring a note from the doctor stating the rash is not contagious.

12. I/We understand that by law my/our child is not permitted to attend StarBright ABA if he/she has contracted a communicable disease. Examples of communicable diseases are (but not limited to): Conjunctivitis (pink eye), Impetigo, Hepatitis A, Scabies, Ringworm, Infectious Diarrhea, Chicken Pox, Scarlet Fever, Lice, and Strep Throat. I/We understand that if my/our child is thought to have a communicable disease I/we will be contacted and that my/our child will be required to be picked up. I/We further understand that my/our child will not be permitted to attend the center until a doctor's note has been provided stating that my/our child is no longer contagious.

13. I/We understand that if it is thought to be a child at the center has a communicable disease all parents will be notified and advised of what symptoms to watch for.

Observation of Client

14. I/We understand that my/our child may be videotaped while attending StarBright ABA for the purpose of training staff members at StarBright ABA and receiving visual updates on my/our child's procedures and progress. I/We understand that the StarBright ABA will keep the videotapes confidential.

15. I/We understand that professionals, other clients, potential clients, staff, and other interested parties will occasionally be coming through StarBright ABA to see the program, setting, and children at which time my/our child will be observed in this environment.

16. I/We understand that I/we may view my/our child while he/she is receiving therapy. I/We understand that during this time I/we should only focus on my/our child's therapy and not any other child's therapy that may be going on in the room.

StarBright ABA Staff Members

17. I/We understand that the staff at StarBright ABA are hired and trained to provide services to my/our child during regular operating hours. I/We understand that I/we am/are not to approach the staff at StarBright ABA with alternative propositions of working with my/our child on or off StarBright ABA premises. I/We understand that StarBright ABA may dissolve their relationship with me/us and/or seek legal remedies should I/we violate this agreement.

18. I/We understand that the staff members of StarBright ABA are not permitted to drive anywhere with my/our child in the car unless it is an emergency. I/We understand that staff members are not to be approached for chauffeuring my/our child back and forth to StarBright ABA.

19. I/We understand that my/our child will rotate through behavioral technicians so that they work with different technicians throughout the weeks. In addition, the StarBright ABA staff will be generalizing their skills to different classrooms and different people. I/We further understand that while StarBright ABA will attempt to reasonably accommodate requests to work with a specific behavioral therapist, StarBright ABA cannot guarantee said request.

Medical Information

20. I/We understand that I/we have agreed to release my/our child's medical and psychological records to StarBright ABA. Releasing these records will allow StarBright ABA to review my/our child's diagnosis, developmental, medical, levels of intellectual, behavioral, and social functioning as well as their medical history. I/We understand that StarBright ABA may require additional medical evaluation and/or testing.

21. I/We understand that I/we must always keep the medication form that is on file for my/our child updated. I/We further understand that at the very least, the director must know what medication and/or supplements my/our child is taking at all times, even if the medication and/or supplements are not administered during StarBright ABA hours. Additionally, if I/we do not wish for the other staff members to know this information the director will respect my/our right to privacy.

22. I/We understand that I/we give StarBright ABA permission to seek medical assistance for my/our child in case of an emergency. Medical attention will be sought without my/our verbal permission if I/we am/are either unreachable, time is of the essence, or other unforeseeable circumstances arise.

23. I/We understand that there are certain medical conditions, as well as certain medications (such as insulin), that the staff of StarBright ABA is not qualified to deal with and/or administer.

If a medical condition arises that the staff is NOT able to handle, my/our child will be dismissed from the StarBright ABA program.

Confidentiality

24. I/We understand that all written materials ("Program Materials") I/we receive during the course of time that my/our child attends StarBright ABA are proprietary in nature and may be used only by me/us for the benefit of my/our child. I/We agree not to disclose, well or otherwise distribute Program Materials to any third party without written consent from StarBright ABA Management. I/We understand that StarBright ABA may dissolve their relationship with me/us and/or seek legal remedies should I/we violate this agreement.

25. I/We understand that data will be taken on my/our child's skill acquisition and behaviors on a daily basis. I/We understand that this data may be used in a research project, presented at a professional conference or meeting, or published in a professional manner. I/We understand that the identity of my/our child or my family will not be revealed without my/our prior permission.

General Information

26. I/We understand that it is my/our responsibility to send a snack in for my/our child. I/We further understand that if I/we choose to, I/we may send in a bulk amount of snack to be stored at StarBright ABA for my/our child rather than sending in a small amount every day. I/we also understand that if my/our child is on a restricted diet that I/we will inform the StarBright ABA staff and they will do their best to make sure that my/our child does not ingest anything that is not an approved food on his/her diet.

27. I/We understand that it is essential that I/we drop my/our child off at their precise designated drop-off time. Furthermore, I/we understand that if circumstances arise that I/we am/are going to be more than ten (10) minutes late I/we will be responsible for bringing my/our child into StarBright ABA and transitioning them to their assigned technician. I/We understand that I/we will not be given a credit for the time my/our child was not at the center.

28. I/We understand that StarBright ABA's staff work on a structured schedule and those 10 minutes of parent consultation time has been worked into the schedule at the end of the therapy session. If I/we arrive late, I/we forfeit the opportunity for parent consultation for that day.

29. I/We understand that all visitors must be approved by the director prior to entering the classrooms.

30. I/We understand that it is my/our responsibility to label all clothing and materials that I send in with my/our child.

31. I/We understand that my/our child is required to wear socks while in the gym at the center. I/We further understand that if my/our child is not wearing socks, or have socks stored at the center, he/she will not be permitted to work/play in the gym that day.

32. I/We understand that StarBright ABA is not responsible for lost, stolen, or damaged materials sent in from home. Furthermore, I/we understand that I/we may not contact StarBright ABA staff outside of standard operating hours to complain and/or inquire about such materials.

33. I/We understand that it is the policy of StarBright ABA not to discriminate against any client on the basis of race, color, religion, gender, physical condition, or national origin.

34. I/We understand that StarBright ABA may dissolve their relationship with me/us and/or seek legal remedies should I/we violate this agreement.

35. I/We understand that StarBright ABA has the **right to terminate services** with my/our child for any reason, at any time. If such termination should occur, the tuition paid to date will be reviewed and may be prorated.

I/we have read and understand the above Rules and Regulations

_________________________________ _______________________________ ______

Signature | Printed Name | Date

_________________________________ _______________________________ ______

Signature of parent/guardian/representative | Printed Name | Date

Photographs & Videos

It is useful to use client photographs and videos in presentations, educational materials, fundraising, etc. Additionally, it is very helpful to use photographs of the clients within the therapy center. Please indicate below your consent for StarBright ABA to take and use pictures and/ videos of your child for these purposes. Declining consent will not affect your access to therapy in any way.

____________ Center Use

____________ Public Use

____________ Declined consent

____ ____________________

Signature (Guardian/Parent #1) Date

____ ____________________

Signature (Guardian/Parent #2) Date

Authorization to Bill for Services

Primary Insurance Carrier ____

Policy Holder Name ______________________ Policy Holder Date of Birth _____________

Identification Number _____________________ Group Number ______________________

Secondary Insurance Carrier ____

Policy Holder Name ______________________ Policy Holder Date of Birth _____________

Identification Number _____________________ Group Number _______________________

I authorize StarBright Applied Behavior Analyst, PLLC to bill my insurance company for medical services rendered and to receive payment directly from my insurance company and I consent to the release of medical information necessary to process any insurance claims. A copy of this authorization may be used in place of the original. I also consent to the release of medical information to other physicians who participate in my child's treatment. The information provided above is accurate to the best of my knowledge. I agree to update my insurance information on file with StarBright Applied Behavior Analyst, PLLC. In the event that I fail to provide updated insurance information, then I will be responsible for payment to StarBright ABA for the cost of services at StarBright ABA's service rates.

Signature ______________________________________ **Date** ___________________