Children's Behavioral Services, LLC

PO Box 683 Willow Springs, MO 65793
(P) 573-883-6761
(F) 417-815-9405
childrensbehavioralservicesllc@gmail.com
www.childrensbehavioralservices.com

CLIENT INTAKE/HISTORY

Client Name: _____ DOB: _____

Gender: _____ Age: _____

Address: _____

Mother/Legal Guardian's Name: _____

Address: _____

Email: _____

Place of employment: _____

Cell phone: _____ Work phone: _____

Father/Legal Guardian's Name: _____

Address: _____

Email: _____

Place of employment: _____

Cell phone: _____ Work phone: _____

Additional Person of Importance to the Child and/or Emergency Contact: If the child is in foster care, please provide the case worker's information.

Name: _____ Relation to child: _____

Address: _____

Email: _____ Phone Number: _____

Individuals Living at home:

Name: _____ Age: _____ Gender: M F

Name: _____ Age: _____ Gender: M F

Name: _____ Age: _____ Gender: M F

Name: _____ Age: _____ Gender: M F

Primary Language Spoken at home: (please circle one)

English Spanish Russian Other: _____

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Primary Care Physician	
Name:	Practice Name:
Street Address:	
City/State/Zip	
Phone Number:	Fax Number:
Physical Exam within the past year? Yes No	
May we contact the Primary Care Physician? Yes No	

CLIENT MEDICAL HISTORY		
Please check the following medical conditions and include dates when relevant		
Autism Spectrum Disorder (ASD)	Stroke	Chronic Fatigue
ADHD	Migraines	Eating Disorder
Intellectual Disability	Liver Damage	Cardiac Problems
Asthma	Thyroid Problems	Urinary Tract Infection
Seizures	Anemia	Persistent flu-like symptoms
Communicable Disease	Diabetes	Chronic Pain
Depression	Cancer	Tuberculosis
Anxiety (e;g., OCD, phobias)	Hepatitis	Substance Abuse/Dependency
Schizophrenia	Hypertension	Bipolar Disorder
Other		
Previous operations, serious illness, injuries, or hospitalizations 1. 2. 3.		Date of treatment/services:
Complications/issues during pregnancy:		
Complications/issues during delivery:		
Current Health/Medical conditions:		

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Food allergies or adverse reactions (explain):
Hearing Difficulties (*note if no previous testing):
Vision Difficulties (*note if no previous testing):

Please provide information on medication and/or nutritional supplements your child is currently taking.

Name of medication or supplement	Dosage (how much)	Frequency & when (how often)	Reason for taking (illness/condition, e.g. sleep, seizures)

Any reactions to medications or side effects the client may experience:

Please provide the following information about your child's diagnosis/diagnoses (ASD, ADHD, Asthma, Seizures, Bipolar Disorder, Anxiety, Depression, etc.)

Diagnosis	Current	Previous	Date of Diagnosis	Diagnosing Physician

Please note that the diagnosis information is required for insurance coverage. By having this information, it assists us when speaking with your insurance company to get authorization for services and providing you with invoices for reimbursement through insurance.

DEVELOPMENTAL HISTORY.

Please indicate the age your child reached the following developmental milestones.

Rolled over:	Sat up unsupported:	Stood:
Crawled:	Walked unassisted:	Pointed to communicate:
First word:	Used 2-3 word phrases:	Used sentences:
Dresses self (partially):	Dresses self (fully):	Sleeps through the night:
Toilet trained (bladder):	Toilet trained (bowel):	Toilet trained (night):

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FAMILY MEDICAL HISTORY		
Please describe the following medical conditions and indicate who suffers these conditions in the immediate family.		
Autism Spectrum Disorder (ASD)	Stroke	Chronic Fatigue
ADHD	Migraines	Eating Disorder
Intellectual Disability	Liver Damage	Cardiac Problems
Asthma	Thyroid Problems	Urinary Tract Infection
Seizures	Anemia	Persistent flu-like symptoms
Communicable Disease	Diabetes	Chronic Pain
Depression	Cancer	Tuberculosis
Anxiety (e;g., OCD, phobias)	Hepatitis	Substance Abuse/Dependency
Schizophrenia	Hypertension	Bipolar Disorder
Hearing Difficulties	Vision Difficulties	PTSD
Other		

CURRENT CONCERNS.
Please indicate and describe if your child is experiencing issues with any of the following:
Eating:
Sleep:
Anger/Frustration:
Social Skills:
Anxiety:
Other:
HISTORY OF RISK BEHAVIORS *(Clinician must complete Risk Assessment document with family if risk behavior is indicated as present)*
Any previous suicide attempts Yes No

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If yes, refer to Appendix A for Risk Assessment		
History of human-induced trauma?	Yes	No
Other risk issues?	Yes	No
Explain:		

PSYCHOSOCIAL HISTORY.
Any spiritual variables which may impact ABA services or treatment:
Any cultural variables which may impact ABA services or treatment:
Significant Life Events:
Interests & Activities (sports, clubs, hobbies, lessons, etc):
Strengths & Weaknesses:
Other:

Please list five (5) specific things you would like your child to do more of and less of in order of priority. For example, instead of listing "be more responsible," translate that into actual behaviors such as "complete household chores, care for brothers, etc."	
I would like my child to do the following more often:	I would like my child to do the following less often
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

EDUCATIONAL HISTORY
School Name:

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District:			
Street Address:			
City/State/Zip:			
Phone Number:		Fax Number:	
Grade Level			
Educational Diagnosis:	504 Plan: Yes No	IEP: Yes No	
Date of most current 3-year Evaluation:	Current Behavior Plan on File: Yes No		
Classroom Teacher			
Time spent in mainstream classroom:			
Number of adults in mainstream classroom:			
Number of students in mainstream classroom:			
Special Education Teacher			
Time spent in Special Education Setting:			
Number of adults in mainstream classroom:			
Number of students in mainstream classroom:			
Please provide information for the following services your child receives at school.			
Service	Frequency (per week)	Duration (min/hr)	Provider
Speech Therapy			
Occupational Therapy			
Physical Therapy			
Other			
Other			
Other			

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BEHAVIOR(S) OF CONCERN		
Behavior:	How often is the behavior emitted:	Duration:
What strategies have been attempted to stop or change the behavior(s):		
How does the client communicate?		
Does the client take care of their own toileting needs?		
Does the client dress him/herself?		
Does the client feed him/herself using utensils? YES NO (circle) Explain:		
What items, activities, sounds, textures, etc. does the client enjoy or could possibly be reinforcing?		

Please provide any additional information that you feel may be important for us: _____

_____

_____

_____

_____

_____

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REINFORCER CHECKLIST TEMPLATE

Please review the following items and place a checkmark on the appropriate line indicating whether or not your child enjoys the items listed and would be motivated by them as a possible reward/reinforcer. Then list specific types or examples of each potential reinforcer.

Edible Reinforcers

Yes
No

If yes, please indicate types of edible reinforcers and provide examples for each:

Salty:
Sweet:
Spicy:
Sour:
Beverages:
Other (please specify):

***Does your child have any food allergies?** Yes No

* If yes, please describe, including any adverse reactions: _____

Tangible Reinforcers

Yes
No

If yes, please indicate types of tangible reinforcers and provide examples for each:

Toys:
Games:
Computer:
iPad:
Movies:
TV shows:
Music:
Materials:
Other (please specify):

Social Reinforcers

Yes
No

If yes, please indicate types of social reinforcers and provide examples for each:

Interacting with parents/guardians:
Interacting with siblings:
Interacting with other family members:

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Interacting with friends:
High fives
Verbal praise
Other (please specify):

Activity Reinforcers

Yes
No

If yes, please indicate types of activity reinforcers and provide examples for each:

Going out in the community:
Singing songs:
Playing teacher:
Indoor activities:
Outdoor activities:
Other (please specify):

Automatic Reinforcers

Yes
No

If yes, please indicate types of automatic reinforcers and provide examples for each:

Spinning:
Staring at lights:
Twirling hair:
Rocking:
Other (please specify):

Please provide any additional information on potential rewards/reinforcers for your child here:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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UPDATED NOTICE OF PRIVACY PRACTICES
HIPAA Compliance Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY BEFORE SIGNING.

Understanding Your Health Information

When you begin working with Children's Behavioral Services, LLC a record of treatment is made. Typically, this record contains your history, assessment, medical information, diagnoses, treatment, a plan for future treatment, etc. This information often referred to as you/your child's clinical record, serves as:

1. Basis for planning your care and treatment.
2. Legal document describing the care you received.
3. Means by which you or a third party payer can verify that services billed were provided
4. A source of data for health officials charged with improving the health of the nation, or needed services for the area.
5. A tool by which future or continual services can be approved.
6. Understanding what is in this record will help you to ensure its accuracy, better understand who, what, when and why others may access your information and help to make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Children's Behavioral Services, LLC the information belongs to you. You have the following rights:

A. Right to Request a Restriction
You have the right to request a restriction on our use and sharing of your protected health information. Children's Behavioral Services, LLC can deny the request if it is unreasonable or would be detrimental to your treatment.

B. Right to a Paper Copy of this Notice
You have a right to obtain a paper copy of this notice.

C. Right to Amend Your Health Information
You have the right to request an amendment to the health information we maintain about you if you feel it is incorrect or incomplete for as long as the information is kept by Children's Behavioral Services, LLC. To request an amendment, you must submit a request in writing and state the reason that supports your request. The disputed information will remain in the record along with the amended information. Children's Behavioral Services, LLC may deny your request if the request is not submitted in writing, does not contain a reason to support the request, the information that is being questioned was not originated by Children's Behavioral Services, LLC, it is not part of the information which you are permitted to inspect or copy, or it is currently accurate and complete.

Health Care Insurance Providers

If we do not file your insurance claims at this time, 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

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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 a clinical diagnosis, or additional 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 that is necessary for the purpose requested. This information will become part of the insurance company 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. We will provide you with a copy of any report or form that we submit upon your request. By signing this Notice, you agree that we can provide requested information to your carrier for authorization of services and if/when you choose to file a claim for any services that we have provided to you or your child.

Others We May Share Your Information With

As required by law we will disclose you/your child's protected health information, even if you do not sign an authorization form, under the following circumstances:

1. Disaster Relief-to an agency organizing disaster relief efforts.
2. Public Health Activities-such as: reporting to a public health or government authority for preventing or controlling disease, injury, or reporting child abuse or neglect.
3. Food and Drug Administration (FDA)-concerning adverse events or problems with products or medications for tracking purposes to enable product recalls or to comply with other FDA requirements.
4. To notify a person who may have been exposed to a communicable disease or may otherwise be at-risk of contracting or spreading a disease or condition
5. For certain purposes involving workplace illnesses or injuries.
6. Reporting victims of abuse, neglect or domestic violence-information will be disclosed as required by law.
7. Judicial and Administrative proceedings-information may be disclosed in response to a court or administrative order, subpoena, discovery requests, or other lawful process. Efforts will be made to notify you about the request or to obtain an order or agreement protecting the information.
8. Health oversight activities-information may be disclosed to a health oversight agency for activities authorized by law, such as, audits, inspections, investigations, licensure actions or other legal proceedings.
9. Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations.
10. To avert a serious threat to health or safety-any disclosure would be made only to someone able to prevent the threat of safety to you/your child, the public or another person.
11. Research-only under your specific disclosure.
12. Workers Compensation.
13. Law Enforcement-as required by law to comply with reporting requirements including, but not limited to: complying with court orders, warrants, subpoenas, summons, identifying or locating a fugitive, missing person or material witness, when information is requested about the victim of a crime if the individual agrees, to report information about a suspicious death, to provide information about criminal conduct occurring at the agency, or information about emergency circumstances about a crime.
14. National Security and Intelligence Activities, Protective Services for the President and others.

Records

We will review all testing results during our meetings with parents/guardians and offer you opportunities to review raw testing data with us. You will receive a written report that summarizes our findings. This

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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 behavioral 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. Because of the proprietary nature of testing materials, we will release raw testing data only to other appropriately credentialed professionals (except as otherwise required by law).

Legal Proceedings
If you are involved in a court proceeding and a request is made for information concerning our professional services, we cannot provide any information without your written authorization or a court order. However, a court order may force us to reveal information. In that case, we will reveal only the minimally acceptable amount of information. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. Also, if a client files a complaint or lawsuit against anyone affiliated with Children's Behavioral Services, LLC, we may disclose any and all relevant information regarding that client we deem necessary in order to defend ourselves.

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 specified information to specific individuals, or under other conditions and as mandated by Children's Behavioral Services, LLC 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 person with a disability 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 but not limited to, notifying the police or an intended victim, a minor's parents, or others who could provide protection, or seek appropriate hospitalization.

Professional Consultations
Board Certified Behavior Analysts and other professionals providing ABA services will routinely consult about cases with other professionals. Therefore, 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. 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.

Your Authorization is Required for Other Uses of Protected Health Information
Children's Behavioral Services, LLC will use and disclose protected health information (other than described in this Notice or required by law) only with your written authorization. You may revoke your authorization to use or disclose protected health information in writing, at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the purposes covered by the authorization except where we have already relied on the authorization.

Our Responsibility Regarding You/Your Child's Protected Health Information
Children's Behavioral Services, LLC is required by law to:

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1. Maintain the privacy of your health information.
2. Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you if we are unable to agree to a requested restriction.
5. Inform you promptly if a breach occurs that may have compromised the privacy or security of your information.

We reserve the right to make changes to this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. Any changes made will affect the protected health information we maintain at that time. We will provide a revised copy of the notice to parents/legal guardians upon request on or after the effective date of revision.

WE WILL NOT USE OR DISCLOSE YOU/YOUR CHILD'S PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION, EXCEPT AS DESCRIBED IN THIS NOTICE.

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our office. If you believe your privacy rights have been violated, you may file a complaint at our service location either in person or by mail.

CONSENT

All information is private and not shared with any outside parties. Agreement of Informed Consent and the HIPAA Privacy Policy described above and the information below must be completed before any services can be provided.

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 above-mentioned HIPAA notice form described above. Consent by all parents/legal guardians (those with legal custody) is required.

Parent/Guardian #1: _____
(Print Name)

Parent/Guardian #1: _____ Date: _____ / _____ / _____
(Signature)

Parent/Guardian #2: _____
(Print Name)

Parent/Guardian #2: _____ Date: _____ / _____ / _____
(Signature)

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Insurance Information

Participant's Name: _____

Participant's phone number (parent #): _____

Social Security # of Participant: _____

Date of Birth of Participant: _____

(If the child is listed on the parent's insurance, please provide me with the primary card holder's information.)

Does child have an Autism Spectrum Disorder Diagnosis? (Y/N) (Please submit copy of diagnostic report)

Date of Diagnostic Evaluation: _____ Name of Doctor: _____

Any other Diagnoses? If so, please list: _____

Name of Primary Insurance Company: _____

Name of Subscriber_____ Subscriber's DOB_____

Relation to child_____

Member ID: _____ Group ID: _____

Insurance Address: _____ Phone number_____

Name of Secondary Insurance Company: _____

Name of Subscriber_____ Subscriber's DOB_____

Relation to child_____

Member ID: _____ Group ID: _____

Insurance Address: _____ Phone number_____

Please provide us with a copy of the front and back of your insurance card(s) if you are going to be seeking reimbursement for services through your insurance company.

****If you have more than one insurance policy on the child, we will need information on both insurance companies. Thank you***

I authorize the release of insurance and benefits information to Children's Behavioral Services, LLC. I understand that a quote of benefits and/or authorization does not guarantee payment from my insurance company. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. I understand that I am responsible for alerting my ABA provider of any changes in my insurance and/or payment status for services.

Signature/Release Date

Revised: 11/2022

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Authorization for Release Form

If your child has a specific diagnosis of Autism Spectrum Disorder F84.0 we need a copy of the diagnostic reports sent from the diagnosing provider. Please include a copy of the report if you have it in your possession. If you do not have a copy available to share with us, please fill out the attached form. The Agency or Individual should be your child's diagnosing physician's name. Please do not forget to fill out the back of the form and sign it. Thank you.

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Authorization for Release to Children's Behavioral Services, LLC

I, _____, (parent/legal guardian name) do hereby authorize _____ (Agency or Individual) to release records to **Children's Behavioral Services, LLC.** Medical information relating to, _____ (child's name) in said facility for the following purpose only:

Include also the following specific type data (check all that apply)

☐ Discharge Date

☐ Diagnostic Reports

☐ Clinic Visits

☐ All information in medical records

☐ Other:_____

Expiration Date:

- The expiration date or expiration event for this authorization is _____.
- If no expiration date or period is known it will expire six (6) months after the date recorded below.
- This authorization covers only treatment prior to the date recorded below.
- I understand I may revoke this authorization at any time with a written request to the above- named facility.
- The request to revoke authorization must contain the signature of the patient or the patient's legal representative and must be notarized.
- Revocation of this authorization is allowable only to the extent that the release of information has not already occurred and/or only the facility has not taken action in reliance thereon.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.
- I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 Code of Federal Regulations, and if there is any such information, I hereby authorize the release of this information.
- This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with HIV (AIDS) virus.

PLEASE CONTINUE ON THE BACK SIDE

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Children's Behavioral Services, LLC is hereby released from all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the applicable federal law.

_____

Signature of Patient or Authorized Individual Date

_____

Relation to Patient if Signed by Other than Patient

_____

Patient Social Security Number Date of Birth

_____

Address

Photo ID Provided ☐ Yes
Witness Signature/Date:_____

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RELEASE OF INFORMATION

Child's Name: _____ DOB:_____

This form provides Amanda Riviello, Children's Behavioral Services, LLC written permission to communicate the following information on the above-named child with

- _____
  Primary care physician or therapist

  - Child's service and progress
  - Evaluation/Assessment and progress reports
  - Health/medical information
  - _____

This release of information will expire one year from date signed, unless revoked by the patient.

I understand, by signing this form, I am providing my consent voluntarily to request or share the information specified on this form.

Parent/Guardian Signature: _____

Date: _____

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INFORMED CONSENT FORM

CLIENT: _____ DOB: _____

STATEMENT OF AUTHORITY TO CONSENT: I certify that I have the legal authority to consent to assessment, treatment, release of information, and all legal issues involving the above-named client. Upon request, I will provide Children's Behavioral Support, LLC with proper legal documentation to support this claim. I further hereby agree that if my status as legal guardian should change, I will immediately inform Children's Behavioral Services, LLC of the name, address, and phone number of the person or persons who have assumed guardianship of the above-named client.

TREATMENT CONSENT: I consent for behavioral treatment to be provided for the above-named client by Children's Behavioral Services, LLC and its staff. I understand that the procedures used will consist of manipulating antecedents and consequences to produce improvement in behavior. At the beginning of treatment behavior may get worse in the environment where the treatment is provided (e.g. "extinction burst") or in other settings (e.g., "behavioral contrast"). As part of the behavioral treatment, physical prompting and manual guidance may be used. The actual treatment protocols that will be used will be explained to me.

I understand that I may revoke this consent at any time. However, I cannot revoke consent for action that has already been taken. A copy of this consent shall be as valid as the original.

PARENT/GUARDIAN: _____ DATE: _____

Amanda Riviello, BCBA, LBA: _____ DATE: _____

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Cancellation Policy

I understand that Children's Behavioral Services, LLC is a pediatric therapy clinic that serves many different patients. I understand that appointments are scheduled so that allotted time for the client is available for each individual client. Regular and consistent attendance and participation in ABA, OT, or SLP therapy is essential for your child to make progress with his/her treatment plan goals and decrease maladaptive behaviors.

Cancellations: If your child is sick and is showing 1 or more of the following symptoms: fever, diarrhea, throwing up, sore throat, or COVID related symptoms, please call as soon as possible, no later than 2-hours before your scheduled session. A 24-hour notice is highly encouraged. All cancellations must be communicated to the office staff. Please call the office and speak to office staff or leave a message. If your child is sick for more than 2 days, a doctor's note must be provided to the front office. After 5 cancellations due to illness within a 3-month period, a doctor's note is required, or this cancelation will be unexcused.

Emergencies: If it is necessary to cancel a scheduled therapy session due to an emergency, please call and cancel as soon as possible, no later than 1-hour before your scheduled session.

Tardies: Tardies are defined as arriving 15 (or more) minutes late to your scheduled therapy session. If you are 15 minutes late to your session, it may be canceled. After **4 tardies**, within a 30-day period, your schedule will be reviewed by the consultant (BCBA) and Company Owner. Your sessions/hours may be decreased or placed on a probationary period until consistent attendance is demonstrated (i.e., 30-days of no cancellations or tardies). If additional tardies or cancellations occur, your case will be reviewed by the Owner to determine appropriate action.

No Call/No Shows: A "no call/no show" is defined as when the client/family does not show up to or is not home for a scheduled therapy session. If a client/family does not contact or respond to the office or the Owner to discuss missed sessions or to reschedule a session within **7 days** of the initial missed appointment, a warning letter will be mailed. From the date the letter is mailed, the family has **7 days** to respond and schedule a meeting to discuss their circumstances with the Owner. If the meeting with the Owner is not scheduled within **7 days**, the client's ABA sessions will be suspended and the responsible party will be notified. If the family would like to resume services, an Attendance Improvement Plan must be signed with the Owner prior to their return.

Children's Behavioral Services, LLC

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Unexcused absence: just a few examples

Excused absence	Unexcused absence
Family vacation with a minimum of 2-week notice	Non-emergency situations with less than a 2-hour notice
Illness with a Doctor's note	Birthday Party
Unforeseen circumstances with a 2-hour minimum notice	No Call/No Show/ "just forgot"
	They are acting tired/Oversleeping

If you miss more than 5% of your scheduled visits per 3-month period (excluding excused absences,) you will be given the Attendance and Participation Improvement Plan.

The missed visit will be rescheduled at the soonest date possible. If the visit is rescheduled, it will not count as a canceled visit. If a missed visit is not rescheduled, it will count towards your missed visit percentage. At owner's discretion, multiple missed visits may result in a cancellation fee billed directly to families.

The owner reserves all right to determine if an unforeseen circumstance will result in an excused or unexcused absence.

Client Name: _____ DOB: _____

Parent/Legal Guardian name: _____

Parent/Legal Guardian Signature: _____ Date: _____

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Electronic Communication and Consent for Use Form

Be advised that the use of email, cell phone texting, and other forms of technology may have security concerns.

Any information exchanged electronically or with the use of technology increases the risk of confidentiality breaches. Communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed or intended for. Therefore, the therapist or implementor cannot guarantee protection from unauthorized attempts to access, use or disclose personal information exchanged electronically. Do not include personal identifying information such as your date of birth, or personal medical information in any emails you send.

Email/texting communication with **Children's Behavioral Services, LLC** will be used for the purpose of simplifying and expediting scheduling/administrative matters only. You should also know that any electronic communication received from you and any responses sent to you may become part of your legal medical record.

Email/texting communication is NOT to be used to provide/receive treatment services to take the place of therapy sessions.

I have thoroughly considered all of the above information. By signing the **Electronic Communication and Consent for Use** form, I consent to the use of email/cell phone texting as needed for scheduling and administrative purposes. Furthermore, if at any time my therapist, implementer, or I believe email/texting is being used ineffectively, either of us can revoke the consent verbally, refuse to respond to email/texts, and insist upon a verbal conversation before proceeding.

Client Name (Printed)	Client Signature
Legal Guardian Name (Printed)	Legal Guardian Signature

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Patient Rights and Responsibilities

Patient Rights

- Receive high-quality service
- Be treated with respect and courtesy
- Have their information kept private and confidential
- Be listened to and have staff work with them to make a plan to address their concerns and needs
- Receive services in offices that are safe, clean and accessible
- Get information and support to help them make decisions to improve their situation
- Be served without discrimination
- Discuss their service with staff to identify if it is working for them and express any questions or complaints that they may have
- To be involved in their treatment
- Request a change of staff member if there is another staff person available who can address their issues -- they should know that discriminatory requests will not be considered
- The right to file a complaint
- The right to refuse treatment

Patient Responsibilities

- Treat the staff and others at Children's Behavioral Services, LLC with courtesy and respect.
- Let Children's Behavioral Services, LLC know 24 hours before if they cannot come to a scheduled appointment.
- Participate in any required task or record keeping as indicated by a Children's Behavioral Services, LLC staff member.

By signing below, I acknowledge I have read and understand the information listed above.

_____

Responsible Party Name (Printed) Responsible Party Signature

_____

Date

Revised: 11/2022

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Client Availability Form

Client Name: _____
Effective Date:_____

DAY	REGULAR AVAILABILITY	OCCASIONAL AVAILABILITY
SUNDAY		
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		

Target Hours:_____

Additional Notes about your schedule and transportation:

_____
_____
_____
_____
_____

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Authorization to Discuss Protected Health Information

Patient Legal Name:_____

Last First M.I. (Maiden)

Date of Birth: _____

I, _____, authorize Children's Behavioral Services, LLC to discuss my medical condition(s), as checked below, with the following contacts:

Full Name of Contact	Relationship to client	Contact Phone Number

I understand that if checked below this will include protected health information relating to:

- Individual Treatment Plan
- Therapy Sessions
- Assessments
- All Protected Health Information

In addition, if checked, I authorize Children's Behavioral Services, LLC to:

- Leave information on an answering machine at (phone number): _____
- Contact me at the following cell phone number: _____

I understand that this authorization is valid for 12 months.

_____ _____

Signature of Patient or Legal Representative Date/Time

_____ _____

Witness signature Date/Time

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Notice of Policies and Practices to Protect the Privacy of Your Health Information (Children's Behavioral Services, LLC will be listed as "ABA")

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.

This notice is to explain the rules around the privacy of you own medical/health records and our legal duties on how to protect the privacy of your medical/health records that we create or receive. Generally, we are required by law to ensure that medical/health information that identifies you is kept private. We are required by law to follow the terms of the notice that are the most current.
This notice will explain:

How we may use and disclose your medical/health information,
Our obligations related to the use and disclosure of your medical/health information and
Your rights related to any medical/health information that we have about you.

This notice applies to the medical/health records that are generated in or by this facility. The terms "medical" and "medical/health" in this Notice means information about your physical or mental condition which make you eligible for our services, or which arise while we are serving you. For example, this may include psychological tests, psychiatric assessments or medical or social assessments.
We may obtain, but we are not required to, your consent for the use or disclosure of your protected health information for treatment, payment, or health care operations. We are required to obtain your authorization for the use or disclosure of your information for other specific purposes or reasons. We have listed some of the types of uses or disclosures below. Not every possible use or disclosure is covered, but all of the ways that we are allowed to use and disclose information will fall into one of the categories.
If you have any questions about the content of this Notice of Privacy Practices, or if you need to contact someone at the facility about any of the information contained in this Notice of Privacy Practices, the contact person is the Privacy Officer or designee:

Amanda Riviello
PO Bos 683
Willow Springs, MO 65793
Phone: 573-883-6761

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In addition to facility departments, employees, staff and other facility personnel, the following people will also follow the practices described in this Notice of Privacy Practices:

Any health care professional who is authorized to enter information in your medical/health record

Any member of a volunteer group, or a student, that we allow to help you while you are in the facility; and

All providers that Children's Behavioral Services, LLC contracts with to provide direct treatment services to our consumers.

In addition, individuals and providers may share medical information with each other about ABA consumers they serve in common for the purpose of treatment, payment or health care operations as those terms are described later in this Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories described different ways that we use and disclose medical/health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Use and Disclosure of Medical Information

We can use or disclose medical information about you regarding your treatment, payment for services, or for facility operations, and we will make a good faith effort to have you acknowledge your copy of the Notice of Privacy Practices.

Treatment: We may use medical (protected health information, or PHI) information about you to provide you with treatment and services. We may disclose medical information about you to doctors, qualified counselors, other behavior analysts, students or residents, or other facility personnel, volunteers or interns who are involved in providing services for you through the facility, or interpreters needed in order to make your treatment accessible to you. For example, your treatment team members will internally discuss your medical/health information in order to develop and carry out a plan for your services. Different departments of the facility also may share medical/health information about you in order to coordinate the different things you need, such as prescriptions, medical tests, special dietary needs, respite care, personal assistance, day programs, etc. We also may disclose medical/health information about you to people outside the facility who may be involved in your medical care after you leave the facility, such as community health/mental health/developmental disability/substance abuse providers or other we use to provide services that are part of your care, but only the minimum necessary amount of information will be used or disclosed to carry this out. Please note that the definition of treatment does allow ABA to share PHI when necessary to consult with other providers, or when necessary to refer you to another provider, or even to treat a different individual.

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Payment: We may use and disclose medical/health information about you so that the treatment and services you receive through the facility may be billed to and payment may be collected from you, an insurance company or a third party payer. For example, we may need to provide your insurance plan information about psychiatric treatment or habilitation services you received through the facility so your insurance plan, or any applicable Medicaid or Medicare funds , will pay use of the services. We may also tell your insurance plan or other payor about a series you are going to receive in order to obtain prior approval or to determine whether the service is covered. We may use or disclose your medical information to a Court about a service you received through ABA in order to collect an unpaid account.

By signing below I have read and understand the information provided to me above.

_____
Responsible Party Name (printed)

_____
Responsible Party Signature

_____
Date

Revised: 11/2022

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Nonviolent Physical Crisis Intervention Release

Children's Behavioral Services, LLC utilizes Nonviolent Crisis Intervention provided by Crisis Prevention Institute as a crisis management system. All staff that may be involved in physical intervention are trained and certified in Nonviolent Crisis Intervention. Please be aware parents cannot be trained by our staff in personal safety techniques and physical interventions (i.e., restraints).

Nonviolent Crisis Intervention's philosophy is Care (showing compassion and empathy); Welfare (supporting emotional and physical well-being); Safety (preventing danger, risk, and injury); and security (ensuring harmony-not harm). The focus of Nonviolent Crisis Intervention is on the client and emphasizes the importance of being supportive and maintaining therapeutic rapport. All staff have been trained to understand the levels of crisis development, how each level of crisis should be approached, and how to proactively prevent any need to use physical intervention by teaching replacement behaviors.

Nonviolent physical crisis intervention is the safe, non-harmful control and restraint positions to safely assist an individual until he/she can regain control of their behavior. Physical management will only be utilized as a last resort when all other less restrictive strategies have been exhausted, or when a person is considered a danger to self or others, according to the procedures provided by QBS Safety-Care per policies established by Children's Behavioral Services, LLC. A serious incident will be documented in a written report and reviewed with the parent/guardian/ witnesses. The report will be submitted to Amanda Riviello and placed in the client's file.

When addressing problem behaviors, client's care, welfare, safety, and security will be our primary focus. Nonviolent Physical Crisis intervention will always be a measure only used to ensure the safety of clients and others. If you have any questions or concerns regarding this policy, please contact Children's Behavioral Services, LLC at any time.

If you choose to decline the use of physical intervention, it will be assessed by the Children's Behavioral Services, LLC staff including, at minimum, the executive director, supervisor, and therapist the level of risk in the center and home and if services can continue to be provided safely without the use of physical intervention.

Please Initial Below

- □ I prefer my child's therapist help assist my child when physical redirection is needed
- □ I prefer I only help assist my child when physical redirection is needed
- □ I prefer we both together assist my child when physical redirection is needed

I have fully read, understand, and have inserted my initial next to my preference to the above in this Nonviolent Physical Crisis Intervention Release.

Please sign on the back page.

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Child's Name Print

Parent/Guardian Print Name

Parent/Guardian Signature Date

Clinician - Print Name

Clinician Signature Date

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WAIVER AND RELEASE OF LIABILITY

IN CONSIDERATION OF the risk of injury that exists while participating in the Sensory Gym (hereinafter the "Activity"); and

IN CONSIDERATION OF my desire to participate in said Activity and being given the right to participate in same;

I HEREBY, for myself, my heirs, executors, administrators, assigns, or personal representatives (hereinafter collectively, "Releasor", "I" or "me", which terms shall also include Releasors parents or guardian if Releasor is under 18 years of age), knowingly and voluntarily enter in this WAIVER AND RELEASE OF LIABILITY and hereby waive any and all rights, claims or causes of action of any kind arising out of my participation in the Activity; and

I HEREBY release and forever discharge CHILDREN'S BEHAVIORAL SERVICES, LLC, located at 910 Springfield Rd., Willow Springs, Missouri 65793, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors, and assigns (collectively "Releasees"), from any physical or psychological injury that I may suffer as a direct result of my participation in the Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH PARTICIPATING IN THIS ACTIVITY, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO: PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE, CONDITIONS RELATED TO TRAVEL TO AND FROM THE ACTIVITY, OR FROM CONDITIONS AT THE ACTIVITY LOCATION(S). NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN AND UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY.

I FURTHER AGREE to indemnify, defend, and hold harmless the Releasees against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs.

I FURTHER ACKNOWLEDGE that Releasees are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Releasees. In that event that I should require medical care or treatment, I authorize Children's Behavioral Services, LLC to provide all emergency medical care deemed necessary, including but not limited to, first aid, CPR, the use of AEDs, emergency medical transport, and sharing of medical information with medical personnel. I further agree to assume all costs involved and agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

I FURTHER ACKNOWLEDGE that this Activity may involve a test of a person's physical and mental limits and may carry with it the potential for death, serious injury, and property loss. I agree not to participate in the Activity unless I am medically able and properly trained and I agree to abide by the decision of the Children's Behavioral Services, LLC official or agent, regarding my approval to participate in the Activity.

I HEREBY ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE Children's Behavioral Services, LLC AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST Children's Behavioral Services, LLC FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for ordinary negligence, this release is also for such negligence on the part of Children's Behavioral Services, LLC, its agents, and employees.

I agree that this Release shall be governed for all purposes by Missouri law, without regard to any conflict of law principles. This Release supersedes any and all previous oral or written promises or other agreements.

In the event that any damage to equipment or facilities occurs as a result of my or my family's or my agent's willful actions, neglect, or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any such actions of neglect or recklessness.

THIS WAIVER AND RELEASE OF LIABILITY SHALL REMAIN IN EFFECT FOR THE DURATION OF MY PARTICIPATION IN THE ACTIVITY, DURING THIS INITIAL AND ALL SUBSEQUENT EVENTS OF PARTICIPATION.

THIS AGREEMENT was entered into at arm's-length, without duress or coercion, and is to be interpreted as an agreement between two parties of equal bargaining strength. Both participant, _____and Children's Behavioral Services, LLC agree that this agreement is clear

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and unambiguous as to its terms, and that no other evidence shall be used or admitted to alter or explain the terms of this agreement, but that it will be interpreted based on the language in accordance with the purposes for which it is entered into.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase, or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written, construed, and enforced as so limited.

In the event of an emergency, please contact the following person(s) in the order presented:

Emergency Contact	Contact Relationship	Contact Telephone
_____		
_____		

I, THE UNDERSIGNED PARTICIPANT, AFFIRM THAT I AM OF THE AGE OF 18 YEARS OR OLDER, AND THAT I AM FREELY SIGNING THIS AGREEMENT. I CERTIFY THAT I HAVE READ THIS AGREEMENT, THAT I FULLY UNDERSTAND ITS CONTENT AND THAT THIS RELEASE CANNOT BE MODIFIED ORALLY. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND THAT I AM SIGNING IT OF MY OWN FREE WILL.

Participant's Name: _____

Participant's Address: _____

_____

Signature: _____

Date: _____

.

PARENT/GUARDIAN WAIVER FOR MINORS

In the event that the participant is under the age of consent (18 years of age), then this release bust be signed by a parent or guardian, as follows:

I HEREBY CERTIFY that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this individual.

Parent/Guardian Name: _____

Relationship to Minor: _____

Signature: _____

Date: _____

Revised: 11/2022

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Mandated Reporter Disclosure Form

All staff for the therapy program operated by Children's Behavioral Services, LLC are mandated reporters as deemed so by Missouri state rules, regulations, and laws. This is true of all social workers, teachers, etc., and should not restrict the work to be completed. This is a state law designed to protect children from injury and should not be viewed as means to harm parents and caretakers.

This form shall serve as a reminder to the family of this fact and shall also provide insight into what this disclosure means. This disclosure shall serve as part of the client education regarding the program, and the client information packet.

Being deemed a mandated reporter, the therapist for the Children's Behavioral Services, LLC program is required by law to report any and all allegations, reports, and suspicions of child abuse, neglect, and maltreatment to the appropriate identified governing body.

Child Protective Services is the governing body identified in the state of Missouri regarding cases of child abuse, neglect, and maltreatment, and the therapist is required and shall, therefore, report the incidents mentioned above to the National Hotline for Child Protective Services.

Any report to Child Protective Services, where deemed necessary by them, shall constitute a separate case from the one managed by Children's Behavioral Services, LLC program. For this reason, it should be noted that the staff shall only participate in CPS cases as required and requested by Child Protective Services. The program operated by Children's Behavioral Services, LLC shall play no part in decisions made by Child Protective Services and should be viewed as a separate organization from Child Protective Services.

The client shall sign a Mandated Reporter Disclosure Receipt Form that shall be kept in the client's file as evidence that the information mentioned above has been provided to the client and family.

Mandated Reporter Disclosure Receipt Form

I, _____, have read and received a copy of the Mandated Reporter Disclosure Form policy from the therapy staff of Children's Behavioral Services, LLC agency.

Childs name: _____

Parent Signature Date

Children's Behavioral Services, LLC Staff Signature Date

Revised: 11/2022

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Behavioral Health Coordination of Care Consent Form

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information in order to provide you with treatment, receive payment for your care, and manage and coordinate your care. However, your consent is needed to share certain types of health information. This form allows you to provide consent to share the following types of information.

- Behavioral health services

This information will be shared to help diagnose, treat, manage and get payment for your health needs.

By signing this form, I understand:

- I am giving consent to share my behavioral information.
- My information may be shared among each agency and person listed below.
- My information will be shared to help diagnose, treat, manage and pay for my health needs.
- My consent is voluntary and will not affect my ability to obtain treatment, payment for medical treatment, health insurance or benefits.
- My health information may be shared electronically.
- Other types of my information may be shared with my behavioral health information. HIPAA allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.
- The sharing of my health information will follow state and federal laws and regulations.
- I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back.
- I should tell all agencies and people listed on this form in writing when I withdraw my consent.
- I can have a copy of this form, upon request.

PLEASE CONTINUE TO THE BACK SIDE

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I consent to share (check only one):

☐ All of my behavioral health information

☐ None of my behavioral health information

☐ All of my behavioral health information and substance use disorder information except:

_____

☐ Other: _____

I consent to sharing my information between: Children's Behavioral Services, LLC PO Box 683 Willow Springs, MO 65793 and the following primary care physician and/or practice:

_____

_____

By signing this form, I understand I am giving consent to share my behavioral health information.

Patient Name: _____ DOB: _____

_____

Signature of person giving consent or legal representative Date

Relationship to patient: (please check one) ☐ Self ☐ Parent ☐Guardian

My consent will expire on the following date unless I withdraw my consent. (If expiration date is left blank or is longer than one year, the consent will expire 1 year (365 days) from the signature date.)

Expiration Date: _____

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Agreement to Videotape - Audiotape – Photograph

Children's Behavioral Services, LLC staff may take photographs or videotapes for marketing, education, or training. Parents acknowledge that they and their child may be photographed or videotaped during a session. Parents give Children's Behavioral Services, LLC permission to use their image at any point in the future for the purposes of marketing and training. Videos and pictures will ONLY be taken with Children's Behavioral Services, LLC equipment. Children's Behavioral Services, LLC Staff are not allowed to record any videos, pictures, or audio using his or her personal equipment. Clients/Parents must receive written permission from Children's Behavioral Services, LLC before videotaping portions of sessions or taking pictures of Children's Behavioral Services, LLC staff.

Permission to Photograph, Videotape, or Audiotape

☐ I do not give permission to photograph, videotape, or audiotape

☐ I give permission and consent for Children's Behavioral Services, LLC to videotape and audio tape my child and myself during the time my child is enrolled in services. I understand these files will not be used outside the company and will be kept confidential.

☐ I give permission for Children's Behavioral Services, LLC to use photograph, videotape, or audiotape for marketing, education, or training purposes.

Client or Child's Name

Parent/Guardian Signature Date

Parent/Guardian (Print)

Revised: 11/2022

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Authorization to Pick Up a Minor Client from Children Behavioral Services, LLC

Name of client:_____

I hereby inform Children's Behavioral Services, LLC that the people listed below are authorized to pick up the above-named child(ren) at any time. Accordingly, Children's Behavioral Services, LLC is hereby instructed to release my child(ren) into the care of the following people whenever they come to Children's Behavioral Services, LLC.

AUTHORIZED PICK-UP PERSON:

Full Name of Contact	Relationship to client	Contact Phone Number

I understand that: Parents/guardians must inform Children's Behavioral Services, LLC (call, verbally inform, leave a note at drop off) of the name of the person who is picking up their child on any day when they themselves are not. The "Authorized Pick-Up Person" must be at least 18 years old and may be asked to provide a photo ID to the staff. This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.

Authorized by:

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

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Client Illness Policy Template

To prevent the spread of communicable diseases, it is our policy that parents/guardians must notify Children's Behavioral Services, LLC staff in advance if your child is sick within 24 hours of a treatment session, preferably the evening before the scheduled session if you know that your child will not be able to participate in the ABA program the next day.

Sickness includes, but not limited to the following:

a. Temperature above 100
b. Mumps
c. Pin Worm
d. Ring Worm
e. Communicable Disease
f. Measles
g. Lice
h. Chicken Pox
i. Vomit
j. Diarrhea
k. Rash
l. Pink Eye
m. Strep Throat
n. Staph Infection

Parents/legal guardians are asked to use the same guidelines used in schools and day care centers. If a child is too sick to attend school or day care then he/she is too sick to participate in his/her ABA therapy session.

ABA therapy will resume as soon as the child's doctor clears him/her of being contagious or the remedy is completed. Parents/guardians must provide documentation of a doctor's note in order for your child to return to ABA treatment.

If your child arrives at the clinic and is sick, our staff will advise you to take your child home. If for home programming, a therapist arrives at the home and the child is sick, the therapist will not be able to work with your child and you will be charged for the session, which will not be reimbursable through insurance, for failure to report your child as sick and adhere to this policy.

I/We understand Children's Behavioral Services, LLC's policy on client illness and agree to adhere to this policy.

Parent/Guardian #1: _____
(Print Name)

Parent/Guardian #1: _____ Date: _____ / _____ / _____
(Signature)

Parent/Guardian #2: _____
(Print Name)

Parent/Guardian #2: _____ Date: _____ / _____ / _____
(Signature)

Children's Behavioral Services, LLC

PO Box 683 Willow Springs, MO 65793
(P) 573-883-6761
(F) 417-815-9405
childrensbehavioralservicesllc@gmail.com
www.childrensbehavioralservices.com

Family Involvement Contract

Initials:	Expectations:
_____	Attend all scheduled sessions (including sessions scheduled in the home or at the center)
_____	A parent or guardian must be present at all sessions
_____	Collect necessary data after training by clinician
_____	Provide and use reinforcement after trained by clinician
_____	Follow clinician suggestions about using reinforcement (may include limiting food items, restricting access to toys, buying new toys)
_____	Modify or adjust the way I respond to my child as described in the intervention plan and suggested by the clinician
_____	Allow clinician to collect data on interactions between client and parent
_____	Allow clinicians to use prompts and rewards (that may include physical contact) with client
_____	Maintain contact with team of implementers (including scheduling, maintaining communication, and monitoring child's performance)

☐ I decline services

_____ _____

Parent/Guardian/Caregiver Signature Date

_____ _____

Clinician Signature Date

Revised: 11/2022

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Fee Agreement and Payment Policy

Our agency strives to offer the highest quality of ABA services to you and your family. Considerable care has been taken to ensure our fees and our rates accurately reflect the complexity of our services, the skills, and expertise of staff required for your child's care. Our fees are comparable to those of other highly qualified specialists.

PRE-AUTHORIZATION: If pre-authorization for applied behavior analysis is required through your insurance company for either in-network or out-of-network services, please let us know and we will work with your insurance company to get pre-authorization.

OUT-OF-NETWORK: I/We agree to pay Children's Behavioral Services, LLC for all services when services are rendered. If my insurance company provides financial assistance for services, I/we do understand that I/we need to pay the fees at the time services are rendered and allow the insurance company to reimburse me/my family. The percentage of reimbursement that you will receive will vary depending upon your insurance company and plan as Children's Behavioral Services, LLC is an out-of-network provider with the following insurance companies: However, most insurance companies will cover applied behavior analysis services in full or in part depending upon your plan. For additional information on reimbursement for applied behavior analysis, please review a copy of the Autism Bill on our website. Staff will provide you with an invoice with the proper codes for you to submit to your insurance company for reimbursement. It is strongly recommended that you submit copies of these invoices to your insurance company **immediately** after you receive them, as insurance companies vary in the amount of time that it will take to reimburse you.

IN-NETWORK: is in-network with the following insurance companies. We will assist in filing all of your claims for applied behavior analysis services. I/We agree to pay for all co-pays and deductibles when services are rendered.

Payments for services are billed per hour.

LATE FEES AND COLLECTIONS: If payment is not received when services are rendered, a % service charge will be added for each week the balance is past due. If payment is not received within days, the bill may be sent to a collection agency. Additionally, I/we understand and agree to pay any and all collection costs and/or attorney fees if any delinquent balance is placed with an agency or attorney for collection, suit, or legal action. I/We also acknowledge that confidentiality is waived in matters involving collections and the sharing of information sufficient to pursue recovery of debts owed. Also, if your check is returned by the bank you will be billed a $. returned check fee and alternative arrangements will have to be made to satisfy your obligation. For your convenience, we accept MasterCard, Visa, American Express, Discover, cash, and checks.

RATES FOR SERVICES:

Insert fee schedule here for out-of-network services and travel charges, if applicable.

*If we are in-network with your insurance then the rates are different based upon our negotiated rates with your provider and cannot be disclosed. The rates above are our standard out-of-network rates.

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CANCELLATION POLICY: We understand that emergencies and illnesses arise which may cause a session to be canceled. However, you must notify us at least 24 hours in advance of any cancellation. If notification is not made at least 24 hours in advance and there is not an emergency situation, you will be billed a cancellation fee equal to the amount of your financial responsibility for the regular scheduled session, **which will not be reimbursable through insurance**. In addition, if a client arrives late to a scheduled appointment, the client will be billed the rate of the full appointment and the wait time will not be charged to insurance and you are responsible for the payment of the time staff were waiting to render services. Repeated failures to attend scheduled sessions or arrive at scheduled sessions may result in termination of services.

If you have any questions regarding our Fee Agreement and Payment Policy, please do not hesitate to discuss it with us by contacting . If you have any questions or concerns regarding billing and insurance, please contact our billing specialist, , at ( ) - .

I/We have carefully read and agreed to this Fee Agreement and Payment Policy. I/We agree to abide by these terms outlined in this document.

Parent/Guardian #1: _____
(Print Name)

Parent/Guardian #1: _____ Date: _____ / _____ / _____
(Signature)

Parent/Guardian #2: _____
(Print Name)

Parent/Guardian #2: _____ Date: _____ / _____ / _____
(Signature)

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Financial Assistance

Children's Behavioral Services, LLC offers financial assistance in the form of an **early pay discount**. The terms of the discount are as follows:

- Clients must be offered the discount by the owner.
- Clients must pay for monthly sessions in full before the 5th of the month.
- Only five early pay discounts are available at any one time.
- Client must not have insurance that covers therapy services.
- For every 4 hours of implementation by RBT or COTA, 1 hour supervision by Board Certified Behavior Analyst or Occupational Therapist must be completed.
- No discount is offered on assessments as this may require 2 or more staff, the use of standardized testing, and report writing/treatment planning. The price per hour for an assessment is $150.

The ***early pay discount*** applies to clients meeting the above terms. **Early pay discount** is only applicable for services offered at our Willow Springs, MO clinic. The ***early pay discount*** price list is as follows:

Applied Behavioral Analyst - Ongoing Therapy	Occupational Therapy- Ongoing Therapy	Speech Language Pathologist- Ongoing Therapy
Board Certified Behavioral Analyst ● Charged rate $140 per hour ● **Discount rate $90 per hour*	Occupational Therapist ● Charged rate $140 per hour ● **Discount rate $90 per hour*	Speech Language Pathologist ● Charged rate $140 per hour ● **Discount rate $90 per hour*
Registered Behavioral Technician ● Charged rate $80 per hour ● ** Discount rate $40 per hour*	Occupational Therapist Assistant ● Charged rate $120 per hour ● **Discount rate $70 per hour*	Speech Language Pathologist Assistant ● Charged rate $120 per hour ● **Discount rate $70 per hour*

*The ***early pay discount*** program is subject to change without prior notice. The early pay discount program can be terminated at any time by Children's Behavioral Services, LLC.