Office: (904) 201-9129
Fax: (615) 694-3915
www.abaconnection.com

Intake Date:_____

New Client Registration

Client Legal Name: _____
Last Name First Name Middle Initial

Name Client goes by: _____ Date of Birth: _____ Gender: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Family Information

Client currently lives with: _____

☐ Biological Parent(s) ☐ Adoptive Parent(s) ☐ Foster Parent(s) seeking Adoption ☐ Foster Parent(s) sheltering

Client has previously lived with: _____

☐ Biological Parent(s) ☐ Adoptive Parent(s) ☐ Foster Parent(s) seeking Adoption ☐ Foster Parent(s) sheltering

Cultural/Religious Considerations: _____

Legal Guardian (First Contact)

Name: _____Relationship: _____

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

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Home Parent/Guardian 1

Name (if different): _____Relationship: _____

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

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Parent/Guardian 2 ☐ Full Contact/No limitations ☐ Unsupervised Contact ☐ Supervised Contact ☐ No Contact

Name: _____Relationship: _____

Address: (if different) _____ City: _____ State: _____ Zip: _____

Home Phone: (if different) _____ Cell Phone: _____

E-mail Address: _____

Emergency Contact Information

I give permission to ABA Connection, LLC to take whatever emergency decisions are judged necessary for the care and protection of my child while in the care of their employees. Please provide the name and phone number of individuals who can be called in case of an emergency when parents/guardians are not available.

Emergency Contact: _____ Relationship: _____

Home Phone Number: _____ Cell Phone Number: _____

Insurance Information

I understand that in some medical situations, the staff will need to contact local emergency resources before the parent/guardian, child's physician and or other adult acting on the parent/guardian's behalf.

Name of Primary Insurance: (Private or MA) _____

Member Number/MA number: _____ Group Number: _____

Subscriber Name: _____

Name of Secondary Insurance: (If Primary insurance is private) _____

Member Number/MA number: _____ Group Number: _____

Subscriber Name: _____

I prefer:
___ Pay my balance in full at time of service
___ Pay my balance in full upon receipt of first statement
___ Make payment arrangements prior to services being rendered
___ Another party is determining payment

Assignment of Insurance Benefits

I understand the confidentially of my records as protected by law. Information about me/my child cannot be released without my consent. I understand I may revoke this consent at any time, and it will automatically expire without my revocation after one (1) year from the date of signature.

I hereby give authorization for ABA Connection, LLC to contact and inform my primary and secondary (if applicable) insurance companies of all medical information included in treatment plans relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressively agree and acknowledge that my signature on this documents authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize the Insurance Companies named above to pay and hereby assign directly to RCC/RCA all benefits, if any, otherwise payable to me for his/her services. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received and paid to RCC/RCA will be credited to my account, in accordance with the above assignment.

_____ _____

(Authorized signature of Subscriber) (Date)

Medical Information

Hospital/Clinic Preference: _____

Client's Primary Doctor: _____ Doctor Phone Number: _____

Current Diagnoses: _____

Allergies: _____

Current Medications *Continue on Notes page if more room is needed on Page 23			
Name	Dosage	Frequency	Rationale

List any medical restrictions to client's activities: _____

_____

List any special dietary needs: _____

_____

Previous Diagnoses & Medications: _____

Additional Service Providers

Social Worker: _____ Phone Number: _____

Interpreter: _____ Phone Number: _____

School: _____ Grade: _____

Teacher's Name: _____ Phone Number: _____

If in school, what is the education status (specialized classroom, aide required, treatments received in school, etc.)? (Need copy of IEP) _____

Developmental and Behavioral Information

Family history that may have contributed to current problem behavior? _____

_____

Meaningful day activity? □ School □ Day Program/Camp □ None □ Other: _____
Any problem behaviors demonstrated there? □ Yes □ No □ Not Applicable

Therapy History: Complete this table for PAST therapies/services utilized to help individual with problem behavior(s).

Service	Location	Last Seen (approximate)	Effective?
Mental Health Counselor			
Substance Abuse			
Outpatient Behavior Therapy			
Baker Act/Short-Term Inpatient			
Inpatient Treatment (7+ days)			
Residential Facility, short-term (90 days or less)			
Residential Facility, long-term (90+ days)			
Other (explain)			
Other (explain)			
Other (explain)			

What did you like about previous treatments? _____
What did you not like about previous treatments? _____

Prenatal Substance Use: □ None reported/known □ Smoking □ Drugs □ Alcohol □ Other □ Unknown

Pregnancy Complications: □ None reported/known □ Yes, Explain: _____

Developmental Milestones: □ No Known Delays □ Notable Delays: _____

Trauma History: □ None reported/known □ Physical □ Emotional □ Sexual □ Witness to Abuse

□ Other (Explain): _____

Activities of Daily Living: Complete this table for CURRENT abilities

Toilet/Commode		Uses toilet appropriately when required
		Needs to be taken to the toilet and given assistance
		Incontinent of urine OR feces: Circle ONE
		Incontinent of urine AND feces
		Not applicable
Mobility		Walks independently
		Walks with assistance (i.e. furniture, arm for support)
		Uses aids to mobilize (i.e. frame, sticks)
		Unable to walk
		Not applicable
Communication		Able to hold appropriate conversation
		Shows understanding and attempts to response verbally with gestures
		Can make self understood but difficulty understanding others
		Does not respond to, or communicate with others
	Prior Communication Treatments (if applicable):	
Most effective method to communicate with client (select all that apply):		
□ Vocal Speech □ Sign Language □ Picture Communication □ Assistive Communication Device □ Gestures		
Most effective method used by client (select all that apply):		
□ Vocal Speech □ Sign Language □ Picture Communication □ Assistive Communication Device □ Gestures □ Problem Behavior (yells, screams, etc.)		

What historical records are available for review? (diagnostic report, IEP/IFSP, reports from other service providers, psychiatric assessment). _____

Strengths

Please list all of your child strengths such as drawing, writing, computer, etc.

Weaknesses

Please list all of your weaknesses such as impatience, demanding, poor relationships, etc.

Main Concerns

Please list any concerns the child may have at home or in the community. This may include, but not limited to, sensitivity (i.e. oversensitive to noises, oversensitive to certain material or texture of food), behaviors, communication, social skills and play skills.

Problem Behavior	**Topography** What does the behavior look like?	**Frequency** How often? How many times per day, week, month, year?	**Function?** Why does he do it? Circle selection
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown
			☐ Attention ☐ Escape/Avoid ☐ Sensory ☐ Wants Item ☐ Unknown

Additionally, provide any special accommodations that would help staff to better support the child's progress. (e.g. sensory toys, iPad, etc. ____

____

____

Possible Reinforcers

Please list all or any preferences that your child has shown and put * next to the ones that are highly preferred in each category. Be as SPECIFIC as possible!!

FOODS: (snacks, candies, chocolate – please be specific; kind or brand names)

TOYS: (games, stuff animals, etc.)

PHYSICAL CONTACT: (tickles, hugs, kisses, clapping, back rubs, etc.)

ACTIVITIES: (reading books, swimming, basketball, listen to music, etc.)

OTHER: (any special preferences not mentioned)

CURRENT ITEMS USED TO REWARD GOOD BEHAVIOR:

KNOWN TRIGGERS TO NEGATIVE BEHAVIOR (what client does NOT like):

_____

_____

Service Coordination: Complete this table for CURRENT therapies/services utilized.

Florida Statutes governing Therapeutic Services and Supports require providers to coordinate services. If your child is receiving any of the following, indicate the number of hours of service per day and the frequency of the service.

Service	Number of Hours	Frequency Circle selection
Special Education Services		Per Day Per Week Per Month Per Quarter Per Year
Child Welfare- Targeted Case Management (CW-TCM)		Per Day Per Week Per Month Per Quarter Per Year
Community Alternatives for Disabled Individuals (CADI) Waiver		Per Day Per Week Per Month Per Quarter Per Year
Personal Care Assistant (PCA)		Per Day Per Week Per Month Per Quarter Per Year
Mental Health- Targeted Case Management (MH-TCM)		Per Day Per Week Per Month Per Quarter Per Year
Recreational Therapy		Per Day Per Week Per Month Per Quarter Per Year
Psychiatrist		Per Day Per Week Per Month Per Quarter Per Year
Physical Therapy		Per Day Per Week Per Month Per Quarter Per Year
Speech Therapy		Per Day Per Week Per Month Per Quarter Per Year
Occupational Therapy		Per Day Per Week Per Month Per Quarter Per Year
Collaborative/Wraparound Services		Per Day Per Week Per Month Per Quarter Per Year
Family Psychotherapy Services		Per Day Per Week Per Month Per Quarter Per Year
Other (explain)		Per Day Per Week Per Month Per Quarter Per Year
Other (explain)		Per Day Per Week Per Month Per Quarter Per Year

Other Providers (if applicable)

Name: _____ Type of service: _____ Phone number: _____

Name: _____ Type of service: _____ Phone number: _____

Name: _____ Type of service: _____ Phone number: _____

Caregiver Involvement

According to the Behavior Analyst Certification Board's Ethical Guideline 4.07(b), "If environmental conditions hinder implementation of the behavior-change program, behavior analysts seek to eliminate the environmental constraints, or identify in writing the obstacles to doing so." When all persons working with the individual are consistent with their interactions, client progress can be witnessed more quickly. Troubleshooting any environmental components may also be identified expediently which reduces the likelihood of client regression. Additionally, most insurers require Caregiver Training and Monitoring throughout the course of ABA Services.

Caregiver commitment, participation, and collaboration with ABA Services is integral to the overall progress of your child/ward. The ultimate goal of ABA Services is to provide enough support, training, and education for the individual and their supports to manage without the need for formal services. Please sign below to indicate that you understand that caregiver training will be conducted, and progress monitored over the course of treatment.

I understand that I will have the opportunity to review, revise, and approve of the Treatment Plan, which will include caregiver goals to be monitored. I understand that adherence to caregiver training goals are not mandatory but failure to comply with recommendations may negatively impact client progress.

- € I agree to comply with Caregiver Training and understand that my goals will be monitored.
- € I do not agree to comply with Caregiver Training but understand that my goals will be monitored.

_____ _____
Parent or Guardian (legally authorized representative) Date

_____ _____
Parent or Guardian (legally authorized representative) Date

Therapy Options

ABA Connection, LLC offers in-home and community-based therapy for clients enrolled in our program. Please complete the form below to indicate which therapy you prefer for your child. The information you provide will help us to determine the type of therapy you are seeking for your child. For more specific details regarding either program you may contact ABA Connection at 904-201-9129. **Day Program ONLY services is not an option. Visits and collaboration in the home environment is required.**

When are you available for caregiver training (select all that apply)? € Virtual € In-Person

	Morning (8a – 11a)	Midday (11a – 1p)	Afternoon (1p – 5p)	Evening (5p – 9p)	Not Available
Mondays					
Tuesdays					
Wednesdays					
Thursdays					
Fridays					
Saturdays					
Sundays					

When is the client available for ABA services? € Virtual € In-Person

	Morning (8a – 11a)	Midday (11a – 1p)	Afternoon (1p – 5p)	Evening (5p – 9p)	Not Available
Mondays					
Tuesdays					
Wednesdays					
Thursdays					
Fridays					
Saturdays					
Sundays					

First Date Available for Services? _____

Additional Comments/Questions about service hours: _____

_____

_____

AUTHORIZATION TO RELEASE INFORMATION

Student/Consumer Name: _____ **DOB:** _____
Street Address: _____**City/State** _____ **ZIP:** _____

I understand this release is voluntary and applies to all programs and services operated under the auspices of ABA Connection, LLC. I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. **I understand that I may revoke this authorization at any time by notifying ABA Connection, LLC in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.**

I hereby authorize ABA Connection, LLC to (check all that apply):
Exchange with Release to Obtain from **the parties I have indicated below**

I hereby authorize ABA Connection, LLC to exchange / release / obtain information:
Verbally only In written form only Both verbally and in writing

Organization or Individual receiving/communicating the information:

Name of Organization/Individual: _____

Street Address: _____**City/State** _____ **ZIP:** _____

Phone:_____

Description of information to be exchanged / released / obtained:

- ☐ ALL
- ☐ Education records
- ☐ Evaluation/assessment/eligibility records
- ☐ Medical records
- ☐ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)
- ☐ Other _____

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

The purpose if this release is: _____

_____ _____
Signature of Client or Legally Authorized Representative **Date**

_____
PRINT NAME and Relationship of Legally Authorized Representative to Client

Federal Law: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law prohibits disclosing this material. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

ABA Connection, LLC Consent Form for Applied Behavior Analysis Services

This document describes the nature of the agreement for professional services, the agreed upon limits of those services, and rights and protections afforded under the Behavior Analyst Certification Board's Guidelines for Responsible Conduct of Behavior Analysts. I will receive a copy of this document to retain for my records. All fees for services and payment arrangements will be reviewed separately.

I, _____ [MR./MS. NAME], agree to have my child/dependent, _____ [CHILD/DEPENDENT NAME], participate in applied behavior analysis (ABA) assessment and/or treatment services provided by ABA Connection, LLC. I understand that the specific activities, goals, and desired outcomes of these ABA services will be fully discussed with me in a separate document and that I will have the opportunity to ask for clarification prior to signing this document. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation in services. If these services have been arranged or will be paid for by a third party (e.g., school, insurance plan, state agency), I am aware that the third party has the following rights: determining covered services, determining paid dates of implementation, access to documentation of sessions for billing purposes, access to results of assessments and written reports, but the third party cannot consent to treatment and practices on my behalf. I also understand that my child/dependent is the primary client of the behavior analyst and that services will be designed primarily for _____ [CHILD/DEPENDENT NAME]'s benefit. Any other individuals or agencies (e.g., family, school professionals) who may be affected by the ABA services are considered secondary clients.

If the ABA services focus on increasing _____ [CHILD/DEPENDENT NAME]'s skills, I understand that the first several sessions will consist of assessment activities designed to (a) evaluate his/her current skills (e.g., curricular assessments) and (b) determine which instructional strategies and interventions are likely to prove most effective (e.g., preference assessments, assessment of prompting strategies). The time allocated to these assessments will result in improved intervention. If the services are designed to improve ongoing problem behaviors, I understand that the beginning of those services will include functional assessment and/or functional analysis activities (e.g., interviews, checklists, direct observations) that are designed to provide information critical to the development of effective treatment procedures. I may be asked to assist in gathering some of this information by recording problem behavior as it occurs or in other ways. This process may take 1-2 weeks prior to implementing intervention, but will increase the likelihood of effective intervention.

The subsequent services will be focused on development of and implementation of instructional procedures and/or a behavior intervention plan. Prior to implementation, I will receive a printed copy of the results of any assessment and of any proposed instructional procedures or behavior intervention plans for my approval. The contents of those documents will be explained to me fully and any questions I have will be answered to my satisfaction. Subsequent implementation will involve training in the basics of ABA that are important for the intervention, details about the specific components of the ABA intervention, and direct practice in the components for the family, educators, and/or other service providers. Full participation in these implementation and training activities is critical for a successful outcome. If there is evidence of repeated lack of involvement, ABA Connection, LLC reserves the right to revisit and reconsider the appropriateness of services. See our No Show/Cancellation Policy. Ongoing collection of data will allow evaluation of the effectiveness of the intervention and will assist in developing any revisions that need to be made to ensure a good outcome. When goals outlined in the behavior analysis service plan are achieved, we will discuss the discontinuation of services as we will have achieved our therapeutic objectives. In addition, at regular progress reviews we may also discuss whether continuation of services would be beneficial, and any barriers to continuation.

Behavior analysts are ethically obligated to provide treatments that have been scientifically supported as most effective for _____ [client diagnosis]. I am aware that other interventions that I am pursuing may affect my child's response to ABA treatment. Thus, it is important to make the behavior analyst aware of those interventions and to partner with the behavior analyst to evaluate any associated therapeutic or detrimental effects of those interventions.

I understand that the procedures and outcomes of all assessment and treatment services are strictly confidential and will be released only to agencies or individuals specifically designated by me in writing. In addition, the fact that my child/dependent receives any services is protected and private information. I am aware that ABA Connection, LLC may release information without my prior consent if so ordered by a court of law. I am also aware that providers are legally required to report suspected occurrences of child abuse or neglect or if I or my child present clear and present danger to ourselves or to others.

I understand that the provider agency employs individuals at the RBT and/or BCaBA level who are supervised by a BCBA. I understand that _____ [CHILD/DEPENDENT NAME]'s assessment and treatment services may be observed by supervisors or other employees as part of ongoing training and quality assurance activities. Events occurring in those sessions may be discussed in closed supervision meetings of ABA Connection staff members. All individuals attending these staff meetings are bound by the same confidentiality guidelines as ABA Connection, LLC in order to protect my privacy and that of my child/dependent. I am aware that a record of the treatment will be maintained and this record is available to me in written form upon request.

I understand that it may be necessary to audio- or videotape assessment and/or treatment sessions for supervision purposes. In the event that audio- or videotaping is necessary, I will be informed and asked to give written consent prior to taping. I understand that the recorded material will be used only by ABA Connection staff and only for purposes of improved service delivery. If the assessment or treatment involves formal research that goes beyond normal evaluation or clinical procedures, I reserve the right to consent or refuse to participate.

I reserve the right to withdraw at any time from these services and I understand that such a withdrawal will not affect _____ [CHILD/DEPENDENT NAME]'s right to services. In the event of withdrawal, I may request a list of other credentialed providers in the region. In addition, I reserve the right to refuse, at any time, the treatment that is being offered. I also understand that ABA Connection, LLC reserves the right to terminate the enrollment of _____ [CHILD/DEPENDENT NAME] for failure to adhere to program standards.

I hereby agree to hold harmless and release from any and all liability, ABA Connection, LLC, its directors, officers, employees, agents, affiliates, sponsors, and promoters, as well as, their respective directors, officers, employees, and agents (hereinafter collectively known as "ABA Connection, LLC and its Sponsors"), for any indirect or incidental injury or illness to _____ [CHILD/DEPENDENT NAME], arising out of or in connection with his/her participation in ABA Connection, LLC program. Also, to the fullest extent allowed by law, I hereby waive and discharge my and the Participant's rights, including those of our heirs and assigns, to any and all claims of damages for indirect or incidental injury or illness to _____ [CHILD/DEPENDENT NAME], against ABA Connection, LLC program.

I am aware that the relationship between provider and client is a professional one that precludes ongoing social relationships, giving of gifts, or participation in personal events such as parties, graduations, etc. In addition, I understand that parent/caregiver not affiliated with ABA Connection, LLC must be present for all sessions.

I may request a copy of ABA Connection, LLC's current professional credentials upon request. In addition, any concerns that I have about ABA Connection, LLC's performance can be directed to Joshua or Andrea Stayton, ABA Connection Founding Partners.

Parent/Guardian comments:

-
-
-
-

These policies have been fully explained to me, and I fully and freely give my consent and permission for my child/dependent to participate in ABA services.

_____ _____
Parent or Guardian (legally authorized representative) Date

_____ _____
Parent or Guardian (legally authorized representative) Date

_____ _____
Provider: Andrea T. Stayton, MS, BCBA Date
BCBA Certificate # 1-07-3966

Safety Risk Assessment

In order to provide services in a safe and therapeutic environment, it is important that certain safety standards are met in the home. Please take the time to fill out this form by checking the box under "yes," "no," "don't know," or "N/A" (not applicable) to identify safety risk factors that your child may encounter in the home.

My child…	YES	NO	DON'T KNOW	N/A
1. Places toys or inedible items in his/her mouth				
2. Consumes inedible items				
3. Walks/runs out of the front door without permission if left unlocked				
4. Is able to unlock doors that lead to unsafe areas in/outside of the home				
5. Is not a strong swimmer				
6. Has strong fears/phobias that lead to problem behaviors (runs away from dogs, loud noises, etc.) please list:				
7. Has allergic reactions that require medical attention				
8. Has any comorbid medical conditions (asthma, diabetes, seizures) please list:				
9. Takes medications that require administration from a trained professional				
My home…	**YES**	**NO**	**DON'T KNOW**	**N/A**
1. Is a two-story home or is above the ground floor				
2. Has stairs inside or outside the home				
3. Has a pool				
4. Has a pool with a gate that can be unlocked by my child				
5. Has locks on front doors that can be unlocked by my child				
6. Has screens on all windows				
7. Has beds next to windows that can be opened by my child				
8. Has child safety locks on all cabinets containing toxic substances (household cleaners, bleach, etc.)				
9. Has child safety locks on all weapons (knives, firearms, tools) and/or has weapons stored out of reach of children				
10. Has closed gate/fence surrounding front yard				
11. Has closed gate/fence surrounding back yard				
12. Has electrical sockets covered				
13. Has pets (please list breed/size):				
14. Has an area where pets can be contained if needed				
15. Currently or in the past has had pest infestation				
16. Has a clean area including a table and chairs designated for session instruction				
17. Has temperature controls (heat, AC, and/or fans)				

Other Safety Considerations

ABA Connection's Illness Policy

You must cancel your family member's session if s/he exhibits any of the following symptoms within 24-hours prior to session:

- A temperature of 100.6 degrees or higher
- Diarrhea (2 occurrences in a single day)
- Vomiting (1 occurrence)
- Any rash other than diaper rash
- Eye infection which may include the following symptoms; eye drainage other than clear, persistent redness on white part of the eye
- Bad cold with hacking or persistent cough, productive cough with green or yellow phlegm
- Atypical nasal discharge (i.e. green or yellow)
- Extreme irritability or exhaustion

Before returning to therapy, your family member must:

- Be fever free for 24 hours without the use of Tylenol or similar medication
- Follow antibiotic treatment for at least 24 hours

In case of highly contagious illness, a doctor's note may be required to resume therapy

If your family member is not well enough to attend school, s/he should not attend therapy

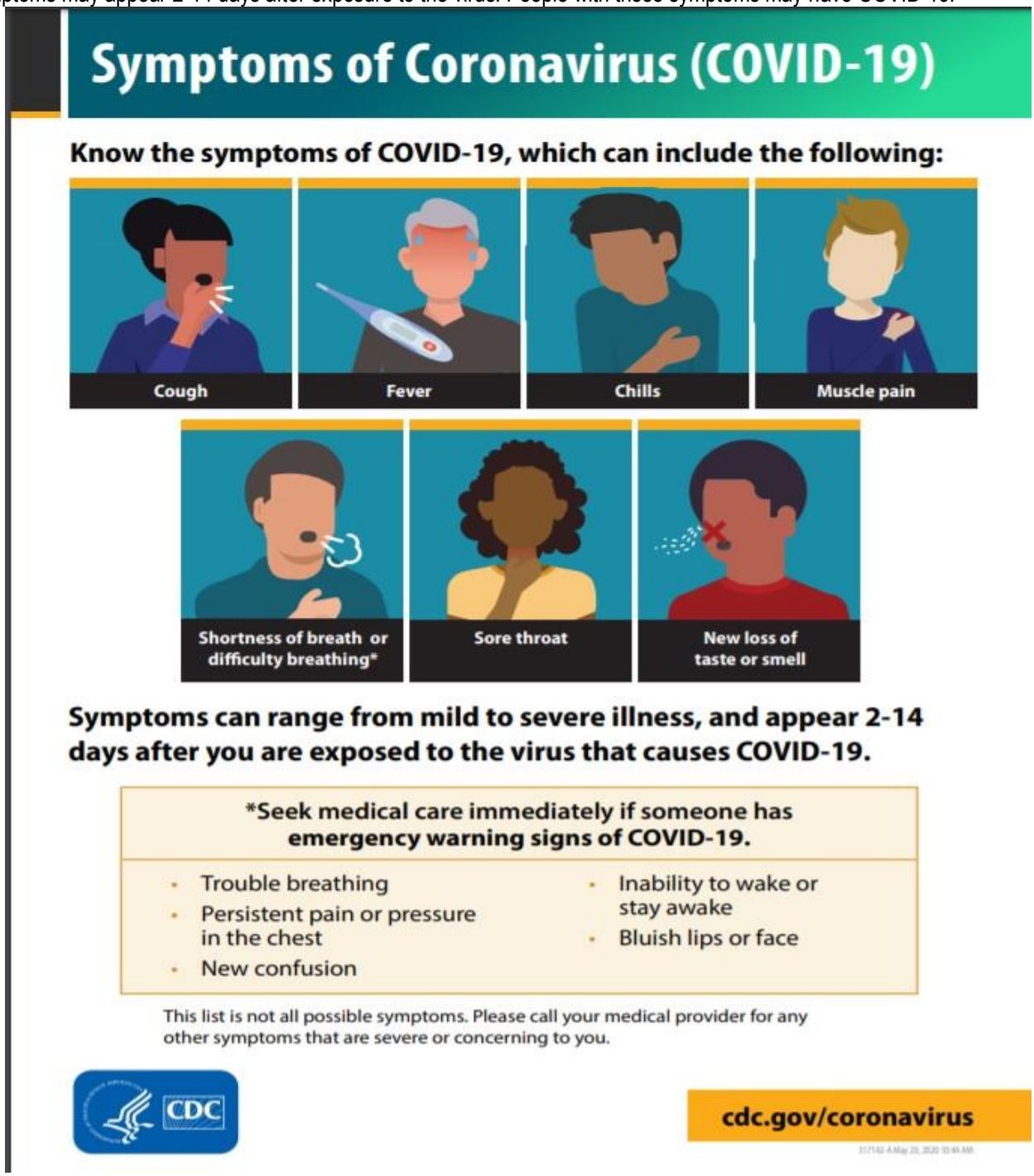
If you need to cancel therapy sessions, please use our scheduling alert at admin@abaconnection.com or call our main office number at (904) 201-9129.

COVID SCREENING

Completion of this questionnaire is mandatory prior to the start of service delivery. If you answer YES to any of the questions below, ABA Connection reserves the right and sole discretion to cancel the session, refuse to allow an individual in a session,

and may discontinue work on site. We appreciate your cooperation as we continue to safely navigate the current state of affairs. Both ABA Connection clients and staff members must complete this form before in-person sessions can occur.

"People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19:



This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19." (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html)

Please answer the following questions to aid us in maintaining compliance with regulations regarding the novel coronavirus. Thank you for taking this time to aid ABA Connection in doing its part for public health.

1. Have you received a COVID vaccine? (Voluntary Admission) □ Yes □ No
2. Are you or any member in your household experiencing noted symptoms above? □ Yes □ No
3. Have you or any member in your household been in close contact with someone experiencing symptoms noted above? □ Yes □ No
4. Have you or any member of your household traveling (in the U.S. or internationally) to an area with known local spread of COVID-19, other than where you currently live? □ Yes □ No
5. Have you or any member of your household been around someone diagnosed with COVID-19 within the past 14 days? □ Yes □ No
6. Have you or any member in your household attended gatherings in excess of 10 people in the last 14 days? (This does not include shopping for essential items.) □ Yes□ No
7. Have you or any member in your household come in contact with any elderly person who may have other underlying diseases or conditions or anyone that has a compromised immune system within the past 14 days? □ Yes □ No
8. Are you ro any member in your household over the age of 65 and/or suffer from other underlying diseases or conditions or anyone that has compromised immune system? □ Yes □ No

Terms and Conditions. Please review and check all boxes if you are in agreement.

- □ **I am fully aware that COVID-19 is highly contagious and I must practice social distancing when possible during ABA Connection service delivery or functions.**
- □ **I understand that ABA Connection is not liable for any exposure to the COVID-19 virus and other health risks that I may sustain during service delivery or ABA Connection functions.**
- □ **I hereby release and hold harmless ABA Connection for any and all legal claims, damages, expenses, and demands arising out of my actions in relation to ABA Service delivery or functions.**
- □ **I do not agree with any of the statements noted above.**

If you answered "yes" to any of the above questions, call your health care provider or your county health department. You may also call 1-866-779-6121 to locate your local health department.

Please visit the self-check tool through the Centers for Disease Control if you are unsure of your current health status. https://covid19healthbot.cdc.gov/

If your response to these questions ever change, please contact ABA Connection administration at (904) 201-9129

School Behavior Therapy Information and Informed Consent Form

Overview of the school Behavior Therapy program

The school-based Behavior Therapy program at _____ School is designed to assist your child to make the most of his or her educational experiences. As your child's therapist, I am concerned about his or her emotional well-being, academic progress, and personal and social development.

This information is intended to provide you with important information about the Behavior Therapy program, the Behavior Therapy relationship, and rights and responsibilities involved in the Behavior Therapy service. Please read this information carefully, and feel free to contact me with any questions you may have regarding the information contained within. It is the policy of the ABA Connection to obtain parent/guardian written permission for Behavior Therapy that extends beyond two sessions in a school year or that is planned on a regular basis. **The final page of this informed consent form may be provided to the school.**

Professional qualifications and experience of the school therapist

Each individual working with your child within the school will be an approved Vendor for the applicable school district and hold a credential provided by the Behavior Analyst Certification Board (BACB). Our practitioners include Registered Behavior Technicians (RBTs) and Board Certified Behavior Analysts (BCBA).

Role of the school therapist

The school therapist, in cooperation with teacher, staff, and administrators at _____ (school), are responsible for providing a collaborative behavioral care to help improve academic and behavioral success within the school system. Comprehensive services include individual student planning and Behavior Therapy services, responsive Behavior Therapy services, and system support services. Each component of the program is outlined below:

- **Guidance curriculum**
  Classroom guidance delivers services consists of classroom lessons that emphasize wellness-based activities that address topics in a preventative manner.
- **Individual student planning**
  Individual student planning involves providing assistance and behavioral information in essential educational meetings, such as IEPs, to help each child obtain determined goals.
- **Responsive services**
  Responsive services involve both direct and indirect services to students. The methods of service delivery for responsive services are individual Behavior Therapy, group Behavior Therapy, consultation, and referrals.
  - Individual Behavior Therapy sessions involve offering direct, short-term service to students to address both proactive and reactive needs.
  - Small-group Behavior Therapy is a direct short-term service designed to respond proactively and reactive to student needs. This format of psychoeducational service offers a variety of small-group experiences on relevant and developmentally appropriate topics such as study skills, anger management, grief, social skills, and other needs-based academic or personal development issues.
  - Consultation is an indirect service which involves collaboration with administrators, teachers, parents, and other Behavior Therapy professionals to address student issues or concerns. The purpose of consultation is to discuss curriculum planning, addressing academic or behavioral interventions, provide training for faculty and staff, assist in coordinating mental health services for students and parents, or planning policy guidelines.
  - Referrals involves enlisting the services of other professionals to assist students in handling complex issues that are beyond the scope and level of expertise of the school therapist.

Confidentiality and its limits

Your child will be participating in the school Behavior Therapy program on a regular basis, and it may involve short-term individual or group Behavior Therapy. Confidentiality is a key feature of the Behavior Therapy relationship with students. In order to build trust with your child, ABA Connection will keep information confidential, with some possible exceptions. The information discussed during the Behavior Therapy meetings will not be shared with anyone except in situations required by law or those specifically addressed in school policy. These situations are described below:

- In the case that the school therapist believes that your child is in danger of harming him/herself or others, blocking may be utilized while awaiting the school's response team. Every effort will be made to cooperate with parents/guardians and inform them first in such a case.
- If instances of abuse, Florida statutes requires the school therapist to report this information to the proper authorities.
- If Behavior Therapy records are court-ordered, the school therapist will make every effort to comply, cooperative with designated parents/guardians, limit the information revealed, and reduce the impact of breaching confidentiality.
- It is the school therapist's responsibility to provide quality care to your child. In order to ensure that quality of care is being provided, consultation with a colleague may be necessary. During this consultation, every effort will be taken to protect the identity of your child.
- If students participate in group Behavior Therapy, limits and responsibilities of group members to maintain confidentiality are discussed and emphasized. However, inadvertent breaches of confidentiality are always a risk. Intentional breaches of confidentiality will have consequences. If the school therapist is aware of any confidential information that has been disclosed, she will make every effort to remediate the situation and notify parents/guardians of the breach. Separate, more specific informed consent will be obtained from students and parents/guardians prior to the student participating in group Behavior Therapy sessions.
- If requests, referrals, or other information about students is transmitted electronically (via phone, fax, or email), privacy cannot be guaranteed. Referrals submitted in writing will be considered confidential and treated as such. However, sensitive or confidential information submitted or forwarded to the school therapist always carries the risk of being accessed by unauthorized persons. Every effort will be made to preserve confidential information of students and their families.

Parent/guardian rights involved in the school Behavior Therapy program

Although the information shared during a Behavior Therapy meeting is confidential, parents/guardians have a right to be informed of their child's general progress. I am required by law to share information with parents and authorities in the event the child is in danger of self-harm or the harm of others. The student and the parent/guardian has the right to refuse Behavior Therapy services or involvement in the school Behavior Therapy program at any time. Refusal of Behavior Therapy participation or services must be documented in writing.

Referrals/arrangements for Behavior Therapy services

Referrals and requests for Behavior Therapy services may be arranged or submitted by parents/guardians, school auxiliary staff, teachers, or other administrators. These requests made be made in writing, by electronic means, or in person. Arrangement for Behavior Therapy services will be considered based on individual need.

Limitations to school Behavior Therapy services

The school therapist's direct services to students will be provided during school hours. Consultation, referrals, reports, and other indirect services may involve the school therapist in after- or before-school activities. The school therapist will provide indirect and direct services to students in a professional manner consistent with the ethical standards outlined by the Behavior Analyst Certification Board. Participation in Behavior Therapy services does not guarantee specific results; however, research supports the benefit of students' involvement in comprehensive behavior analysis programs.

Please review and sign the informed consent form included in this document (see next page).

School Behavior Therapy Informed Consent Form

_____ **School**

Please review the information provided in this document, sign according to the instructions to indicate agreement, and return to ABA Connection.

I, (printed name) _____, am the legal parent/guardian of (printed student name) _____.

I have read and understand the information provided in this document. I given my consent to the terms of this document and agree to the following (check items to indicate agreement) participation.

I give consent to my child's participation in:

_____ School guidance curriculum (classroom activities).

_____ Responsive Services (consultation, small-group Behavior Therapy (by referral), individual Behavior Therapy).

_____ Individual Student Planning (ex: IEP attendance)

I understand that I may withdraw my consent at any time by signing and dating a written note requesting termination of Behavior Therapy services.

Parent/guardian signature: _____

Date: _____ Daytime phone: _____

E-mail contact: _____

PLEASE RETURN THIS SIGNED DOCUMENT TO ABA CONNECTION. IT IS REQUIRED PRIOR TO INITIATION OF SERVICES.

No Show/Cancellation Policy

Client: _____ Birthdate: _____

Regular attendance at scheduled appointments is very important. Our services will not be effective in helping you if you do not keep your appointments. Irregular attendance, especially a "no show," is also inconvenient and costly for the staff assigned to help you. It is therefore your responsibility to attend all scheduled appointments.

Whenever possible, please notify your assigned clinician at least 24 hours in advance if you will not be able to keep your scheduled appointment.

CANCELLATION POLICY: If you call your assigned clinician at least an hour before your scheduled appointment, it is considered a "Cancellation," although 24-hour notice is preferred.

1. After the first cancellation, the staff person will call you to reschedule.
2. After two cancellations in a row, ABA Connection will send you a letter explaining that you must call him/her if you desire to continue services.
3. After the third cancellation in a row, services will be terminated.
4. If you cancel three times, with some attendance in between each cancellation, your therapist will discuss with you some possible solutions to the problem of irregular attendance.

NO SHOW POLICY: If you do not call to cancel at least an hour before the scheduled appointment time, it is considered a "No Show."

1. After the first "No Show," the staff person will call to reschedule the appointment.
    a. If you fail to notify your assigned clinician prior to a missed in-home session, you will be provided with a singular warning following the signed date of this agreement.
2. After the second "No Show," ABA Connection will send you a letter explaining that you will be required to renew your commitment to attend sessions or call the staff ahead of time if you need to reschedule.
    a. Financial Penalty: If you fail to notify your assigned clinician prior to a missed in-home, in-school, or community session, you will be charged a **$25 travel fee** to cover the staff cost of traveling to your home for the missed appointment and loss of work hours. *If your insurance does not permit fees being assessed, this travel fee will be assessed as an un-invoiced balance on your account towards potential termination of services.*
3. After the third "No Show," your case will be closed.
    a. Financial Penalty: If you fail to notify your assigned clinician prior to a missed in-home, in-school, or community session, you will be charged a **$50 travel fee** to cover the staff cost of traveling to your home for the missed appointment and loss of work hours. *If your insurance does not permit fees being assessed, this travel fee will be assessed as an un-invoiced balance on your account towards potential termination of services.*

I understand ABA Connection's No Show/Cancellation policy and understand that regular attendance is necessary for treatment to be effective. Therefore, I agree to attend all scheduled sessions. If I cannot keep an appointment, I will call the staff 24 hours in advance to reschedule. If I have an emergency that prevents me from attending, I will call the assigned clinician at least one hour before the appointment to cancel.

_____ _____

Client (if competent) Date

_____ _____

Parent/Caregiver Date

Additional Information

Thank you for completing the client registration packet. In addition to submitting the application packet, please include the following items when applying for enrollment if these documents have not already been provided:

- Copy of your child's insurance card(s)
- Medical documentation pertaining to the current behavioral diagnoses
- Reports from other service providers (if applicable)
    - Speech therapy, school services, occupational therapy, etc.

Please contact us if you have any questions when completing the application packet, or regarding the intake process.

Thanks again,

Andrea T. Stayton, MS, BCBA
Board Certified Behavior Analyst
Approved Continuing Education Provider
Medicaid Provider ID: 017588300
National Provider ID: 1205071917
O: (904) 201-9129
AStayton@outlook.com
www.abaconnection.com

Notes:

Client Notification of Privacy Rights

Health Insurance Portability and Accountability Act (HIPAA)* See last 2 pages of this packet for Notice of Privacy Practices.

Recent federal law, the Health Insurance Portability and Accountability Act (HIPAA), has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to electronic transmission of data, the keeping and use of client records, and the storage and access to health care records. HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Client Notification of Privacy Rights is designed to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can do to protect the privacy of your mental health records.

HIPAA requires that we secure your signature indicating you have received or been offered the Client Notification of Privacy Rights document.

I have accepted a copy of the Client Notification of Privacy Rights document. ☐ _____

I have been offered a copy of the document and do not wish to have a copy at this time. ☐ _____

(I understand I have the right to review the document before signing this acknowledgement form.)

_____ ☐ _____

Client's Name (print) Client or Legal Guardian Signature

_____ _____

Client Date of Birth Date Signed

Please sign and return this page to the office. You may retain the notification document for you records.

HIPAA Privacy Rights Notification 06-

HealthIT.gov

YOUR HEALTH INFORMATION, YOUR RIGHTS

GET IT. CHECK IT. USE IT.

DID YOU KNOW?

8 in 10 individuals who have viewed their medical record online considered the information useful.[1]

27% of individuals were unaware or didn't believe they had a right to an electronic copy of their medical record.[1]

41% of Americans have never even seen their health information.[2]

HIPAA (Health Insurance Portability and Accountability Act of 1996) gives us the right to access our health information.

KNOW YOUR RIGHTS

Hannah is a 50-year-old woman recently diagnosed with Type 2 Diabetes.

Like all individuals, Hannah has a right to see and get a copy of her health information.

With a copy of your medical record you can become more informed about your health.

SEND YOUR HEALTH INFORMATION TO A THIRD PARTY

You hold the key to your health information and can send or have it sent to anyone you want. Only send your health information to someone you trust.

Your provider is no longer responsible for the security of your health information after it is sent to a third party.

Be careful when sending your health information to a mobile application or other third party.

PROTECT YOUR HEALTH INFORMATION

Once you have a copy of your health information, it is important to keep it protected.

Passwords can protect your health information on your computer or mobile device.

Sources: 1. https://www.healthit.gov/sites/default/files/briefs/oncdatabrief30_accesstrends_.pdf 2. https://www.healthit.gov/buzz-blog/consumer/making-patient-access-health-information-reality/

LEARN MORE ABOUT YOUR RIGHTS

WWW.HEALTHIT.GOV/ACCESS

www.hhs.gov/hipaa/for-professionals/privacy/guidance/access

The Office of the National Coordinator for Health Information Technology

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS

Content created by Office for Civil Rights (OCR)
Content last reviewed on November 2, 2020

NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION
[45 CFR 164.520]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered healthcare provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information. See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any website it maintains that provides information about its customer services or benefits.
- Health Plans must also:
  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.

- Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

- Covered Direct Treatment Providers must also:
  - Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  - When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
  - In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
  - Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice. See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Notice of Privacy Practices:
https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

FAQs on ALL Privacy Rule Topics
https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/consumers/consumer_summary.pdf

You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.