Beyond the Spectrum

ABA Clinic Parent Handbook

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Website: www.beyondthespectrum.org

BCBA: Amy Labrie
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Our Mission - The ABA clinic at Beyond the Spectrum (BTS) is an organization dedicated to providing the highest quality individualized therapeutic and behavioral services in a positive and family friendly environment to children with disabilities such as Autism Spectrum Disorder. Our goal is to support children and their families by providing a strong behavioral and therapeutic program that focuses on assisting the child in adapting to a multitude of environments, such as home, school, and social settings. We are focused on all aspects of the individual's life and aiding them to go beyond expectations to reach their full potential.

Hours of Services:
Monday – Friday 8:30am – 4:15 pm. Service times are individualized per client and the therapeutic services recommended. Please request current calendar of services for days off and early release dates.

The ABA Clinic at Beyond the Spectrum runs year-round with particular holidays and scheduled breaks. The breaks are optional, and you will be given the opportunity to sign up for services during those times. During Christmas break, Thanksgiving break and Spring break, services are optional, and therapy will run for those who wish to participate. Parents will be asked to sign up in advance to continue therapy during those specific times. Therapy will be offered on a first come first service basis during these breaks, based on staff availability.

Philosophy - The programs at The ABA Clinic at Beyond the Spectrum are child-centered and developed around the needs of each child. The principles of behavior analysis are the guiding philosophies of each individualized program. Self-help, functional skills, daily living, communication, and social skills are the basis of each child's program. A board-certified behavior analyst (BCBA) creates and oversees each child's program. Each client has a one-on-one registered behavior technician (RBT) working with them through their own program under the direction of a BCBA.

Admissions Procedures - The prime concern of The ABA Clinic at Beyond the Spectrum is the child and the appropriate placement of each child. Admission is based on information gathered from personal interviews with parents and children, and from available academic, psychological, and physical records when needed. The ABA Clinic at Beyond the Spectrum has no religious affiliation and accepts children without regard to race, color, creed, or national origin.

Enrollment Procedures

1. Once an inquiry has been received through our website (beyondthespectrum.org/aba-therapy-clinic-lwr) you will be contacted to schedule a tour of the facility and learn about our program.
2. Insurance benefits will be checked and if ABA is covered, enrollment paperwork will be provided. Each client will need a diagnosis of ASD, and a comprehensive assessment from a doctor/psychologist such as the ADOS will need to be submitted
3. An assessment authorization will be requested
4. After an assessment is complete, a behavior plan will be written and submitted for authorization
5. Services will be provided based on the BCBA's recommended treatment hours based on the initial assessment.

Parent Training Participation Requirements - Each family will be required to attend a parent training series which consists of parents/caregivers meeting with the BCBA as per individual client's recommended hours in their individualized behavior plan. All parent trainings will focus on goals outlined in the client's BIP and the parent fidelity with those goals. It is imperative that parents participate in ongoing parent trainings for continuation of services through insurance requirements.

Drop-Off and Pick-Up Procedures - Arrival time is specific per client and agreed upon at the onset of therapy. It is important to have your child with his or her therapist by their agreed upon scheduled time.

A staff member will greet your child in designated entry area each morning and meet parents every afternoon. Please accompany your child into the building at drop-off and pick-up. **Never drop off your child and leave without speaking to an adult**. A child should **never** be dropped off at the building entrance and left to enter the building alone. **Your child should not be left unattended by a parent until the client's RBT has taken the child for services.**

When you drop off and pick up your child, please sign in and out on your child's designated clipboard.

Release of Children - A child will be released only to a parent or persons listed on the authorized pick-up list. In the event that child is to be picked up by someone not on the list, a note should be sent in or a phone call made to the office to this effect, and that person's driver's license will be checked against the name given to the center for verification.

Non-Custodial Parent - In the absence of court order to the contrary, The ABA Clinic at Beyond the Spectrum will provide the non-custodial parent with access to any records and to other center-related information regarding the child. If these is a court order specifying that there is to be no information given, it is the responsibility of the custodial parent to provide The ABA Clinic at Beyond the Spectrum with an official copy of the court order. A copy of the court order also is required in instances where the non-custodial parent has been denied access to or contact with the child. If the center has been informed by the custodial parent that the child must not be released to the other parent, then we must have a copy of the court order to support the instructions given.

Communication - Communication among parents, child and center is critical as we work together toward meaningful and functional experiences for your child. Please look in your child's backpack every evening as a folder or binder will be placed inside with communication from the RBT or behavior analyst. This folder should stay in the backpack as it will be used for daily communication to and from the center. We like to keep these on record so please keep them in the binder. If you would like a copy, please let the analyst know. Feel free to add information relevant to your child inside the folder for the analyst and RBT.

Conferences and informal conversations in the doorway as sessions begin are difficult for the analyst or RBT as other clients are engaged in therapy. Should you have a concern and need to speak with the BCBA or RBT, you may send a note or leave a message in the office and the corresponding person will contact you as soon as possible. You may also reach your child's Analyst or RBT through their email address or their communication binder.

Any drastic personal changes in the child's life or home environment should be discussed with the staff as soon as possible. These situations often affect the child's behavior or performance at the center. This includes medication, dietary, or behavioral changes.

Should you have a concern about center procedures or policies, please contact the BCBA and she will be happy to meet with you.

Client Supplies - Clothing and shoes: Each child should bring a full change of clothes with them daily. Please place all clothing items in a large zip top bag labeled with your child's name. A full change of clothes should include socks, underpants, shoes, shirt, and pants/ shorts.

Backpack and lunchbox: Each child should bring a backpack and packed lunch daily. Backpacks and lunch boxes should be clearly labeled with your child's name.

Other items: if your child required pull-ups or wipes, feel free to send in large quantities labeled with your child's name.

Lunch - Please send lunch and a snack with your child's name on it every day. You are welcome to send a weekly supply of an item to leave in the kitchen. Please be sure to clearly label any items with your child's name.

Community Outings - Outings are designed to enhance and generalize your child's learning experiences outside of the clinic or home. The program director or analyst will organize trips throughout the year a schedule of trips for the center year will be posted in the office at the beginning or the week, and parents will be reminded several days in advance before each scheduled trip. Generally speaking, a community outing is scheduled each month.

Every parent must sign a general waiver – transportation form at the time of enrollment. No child will be allowed to leave on a field trip unless this completed form is on file at the center. Each child will have a minimum of a one-to-one adult with them at all times during outings.

All children under the age of eight must have a child safety or booster seat unless the child is taller than 4 feet 9 inches tall. All other children are required to wear seat belts at all times while in the vehicle. No child under the age of twelve years may ride in the front

seat of a vehicle. No child may ride in the front seat of any vehicle with a passenger side air bag unless the child is accompanied by his/her parent.

Cancellations - If there is a cancelation due to an appointment, vacation, or personal reason, **please give the BCBA a 24 hour written notice**. The written notice should state the day(s) that they student will not be at The ABA Clinic at Beyond the Spectrum. If these is an illness or an unexpected situation, please call the Analyst prior to the student's session time to cancel. As much advance notice is greatly appreciated.

Changes in Schedule - If there is a change in schedule such as an appointment, but the student will still be attending the clinic for part of the scheduled session, please provide a written notice. The written notice needs to be sent to the program director at least 24 hours prior to the start of the day. Without this alert there is a chance that your child may not be able to receive the one-on-one therapy due to staff availability. This includes early dismissals that were not scheduled prior. Changes in schedule that are not communicated 24 hours in advance will incur a $25 cancellation/change in schedule fee.

Late Arrivals - If there is an unexpected situation and you are going to be late dropping off your child, please call/text the program director directly. If the parent does not give the program director a written notice at least 12 hours prior to the session, it is considered a "late arrival". The ABA Clinic at Beyond the Spectrum gives the parent one hour from the student's scheduled start time before cancelling the session. After one hour, the session will be cancelled at a $75 cancellation fee. This is to better assist with over-staffing. If you are more than 15 minutes late for any reason and have not contacted the center director, you will be changed for delay at a charge of $1/minute after 15 minutes. This will cover the costs or the assistant who arrived on time to work with your child. Repeated tardiness will be tracked. If this becomes a concern, you may be asked to change your child's therapy time to a later session time._ Repeated tardiness is defined as being late for your session (more than 15 minutes) 2x/month. If you exceed twice a month being tardy even with alerting the center director ,and you continue to be late, You will incur a fee of $1/minute after the 15 minutes. You are always welcome to push back your child's session time on a consistent basis if you are unable to make your scheduled start time.

No-Show Policy - Should a child miss therapy with no previous call from the family to the program director or analyst, the parents will be charged a **$75 no-show fee**. If a child is more than one hour late with no phone call to give notice to the therapist, the no-show late fee will still apply and the session may or may not be provided based upon staff availability. If you are late for your child's session, your child's session time will still end at the scheduled end time. Additional minutes will **not** be added to the end of the session.

Illness -Please call the office in advance if your child is ill and will not be attending therapy. If and when you have verification of the fact that your child has a communicable disease, the center should be notified immediately so that we may inform other parents.If a child becomes ill while in care at The ABA Clinic at Beyond the Spectrum, the center will contact the parent to pick up the child. Illness is characterized by one or more of the following symptoms:

- Temperature of 100 degrees or higher
- Lethargy
- Abnormal breathing
- Uncontrolled diarrhea
- Vomiting
- Rash with fever
- Yellow/Green discharge

Please do not return your child to the center until 24 hours after symptoms subside.

Accident/ Medical Emergencies

If a child is injured while at The ABA Clinic at Beyond the Spectrum, the parent will be notified immediately. If a critical illness or injury occurs, we will contact emergency medical services, give the child first-aid or CPR If necessary, and contact the child's parents.

In the case of an injury that required medical attention, or should there be a situation where a child was at risk, you will receive a copy of an incident report

Medication - All medicines are to be handled by adults only. Children should **not** carry medicine, nor should it be placed in lunch boxes or backpacks. At NO TIME may medicine be brought into the child's classroom or be given directly to the program director, analyst, or RBT to dispense. Medication in its original container with the child's full name and date should be brought to the center by the parent and delivered to the office manager who will store it in a locked location. In accordance with state licensing requirements, at that time, a medication authorization form must be filled out and signed by the parent. If the medication is to be taken for several days, it may be helpful to have your pharmacist divide the dosage into separate bottles for center and home the prescribed medicine will be administered at the time and time recorded in a medication log. Authorization to administer may also be given in an electronic format capable of being saved. Authorization to administer single dose may be given by phone.

Lice - Head lice are a common childhood problem. These small grayish-tan insects without wings attach their eggs, or nits, firmly to hair shafts. The most common symptom if infestation is intense itching on the back of the head or neck. Because list are easily transmitted from child to child, it is the policy of The ABA Clinic at Beyond the Spectrum to call the parents of the child with a suspected active lice infestation and have the child picked up. The child may return to the center after treatment of their hair, clothing and home environment.

Allergies - The center should be advised of any foods or other substances to which your child suffers an allergic reaction. These allergies should be noted on the application form. This information will be given to the program director, analyst, or RBTs, and kept in the office with the first aid kid.

If your child has a severe food allergy, you are required to fill out both the food allergy action plan and the anaphylaxis emergency action plan, located towards the end of this handbook.

Inclement Weather - During hurricane season, please listen to the radio and news stations for school closings. If the public school where you reside is closed, then the center will also be closed. When in doubt, please call our office.

Visiting the Center - Parents are always welcome to visit their child's sessions during center hours. However, please be aware that this may be upsetting to your child and the other children in the center. If you are interested in setting up a time to observe, please contact your center program director to schedule your visit.

Severe Weather Policy
Experiencing a hurricane or extremely severe weather is always a real possibility in Florida. Our BTS closing policy in case of such weather conditions is as follows:

1. All closures and re-openings will follow Sarasota and/or Manatee County School Board decisions
2. The center director will call the number on file by 7:30am to alert families of closures.

Fire Drills - As required by law, BTS conducts monthly fire and/or emergency preparedness drills, as dictated by our emergency preparedness plan. These drills are conducted while the children are present. Every effort will be made to address any auditory sensory issues that any child may have.

Security - We will never release a child into the care of any person whose name is not on the enrollment forms.
Although a name may be on the enrollment form and/or Pick-up List, a pictured identification, preferably a current driver's license must be presented to the BCBA, RBT, or office personnel if they do not personally know you. All parents and/ or designated pick-up person(s) should be prepared to show proper identification if asked. This is not meant as an inconvenience, but is done for the protection and safety of your child.
As part of our efforts to keep your child safe, ALL parents, legal guardians, and authorized pick-up persons MUST complete the Authorized pick up form. Additional copies of this form are available

Grievance Procedure
If there is a disagreement with a policy or a decision, or if you are having a "problem" with your child's therapist, please refrain from discussing this in front of your child or other parents. In the event there is a problem, we ask that the following

procedure be followed:

1. FIRST, speak directly with the therapist in question and try to correct the problem through communication!
2. Schedule an appointment with the BCBA
3. Schedule a meeting with the BCBA, RBT, and executive director

Non-Discrimination Policy - BTS does not discriminate on the basis of sex, sexual orientation, age, race, color, national or ethnic origin, or disability in administration of its admissions or educational policies, scholarship and loan programs, other School-administered programs, or in employment. The School complies with the amended Family Education Rights and Privacy Act, Title VI and Title VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973.

PERMISSION TO PHOTOGRAPH

Client's Name: _____ DOB: _____

I give permission and consent for The ABA Clinic at Beyond the Spectrum to photograph for the following purposes:

- ☐ Crafts/Clinic Projects
- ☐ Educational training presentations
- ☐ Promotional marketing materials
- ☐ Social media
- ☐ Other: _____
- ☐ None, please no photos

_____ _____

Parent/Guardian Printed Name Parent/Guardian Signature

Date: _____

PERMISSION TO VIDEOTAPE OR AUDIOTAPE

I give permission and consent for the ABA Clinic at Beyond the Spectrum to videotape and/or audio tape my child during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Beyond the Spectrum.

_____ _____

Parent/Guardian Printed Name Parent/Guardian Signature

Date: _____

The ABA Clinic at Beyond the Spectrum
7333 International Place
Lakewood Ranch, Florida 34240

SUBJECT: ABA services for your child

Dear Prospective Client,

Thank you for your interest in our ABA clinic. The following pages briefly outlines who we are, the process of getting started, and the client registration forms necessary. The registrations forms within provide us with information to assess how we can best service your child and family. With all these documents completed, we may begin the process on our end toward beginning treatment.

Once you have completed the documents, please drop off, email or mail them to the address above, together with a copy of your insurance card(s) front and back, comprehensive diagnostic report with a diagnosis of Autism Spectrum Disorder (F84.0) and the prescription for ABA Services for Medicaid recipients (if these have not already been provided).

Should you have any questions, comments or concerns, please do not hesitate to contact us! Thank you again for your interest in our organization and we look forward to getting to know your family and child.

Sincerely,

Lora Carpenter, Executive Director
Amy Labrie, MS, BCBA, Director of Clinical Services

Mission

Our mission at Beyond the Spectrum is to serve the children and families in our community affected by autism and related disorders. By providing individualized therapeutic and educational services and utilizing the expertise of our professionally trained staff, our goal is for each child to achieve their highest potential in a safe, caring and family-friendly environment.

Philosophy

The Clinic at Beyond the Spectrum supports evidenced-based treatment methods based upon the procedures and principles of Applied Behavior Analysis (ABA) inclusive of Natural Environment Teaching (NET), Discrete Trial Instruction (DTI), Verbal Behavior strategies and Direct Instruction. We recognize the need to work with the families of our clients as well as collaborate with his/her other therapists.

Each client has an *individualized* program designed to address his/her needs. Once we determine the client has met treatment eligibility requirements and assure our clinic is an appropriate placement for him/her, we begin the treatment process. In order to design a treatment package that best meets the client's needs, our initial assessment includes but is not limited to Functional Behavior Assessments, Preference Assessments, VB-MAPP and ABLLS-R. Each skill area is designed to foster each child's independence and functioning. Goals are established with the collaboration of parents/caregivers and other professionals as part of the multidisciplinary team.

Contact Information

Lora Carpenter
Executive Director
Lora.carpenter@beyondthespectrum.org
941-907-3443

Amy Labrie, MS, BCBA
Clinic Director
Amy.labrie@beyondthespectrum.org
941-907-3443

An Overview of the ABA Approach to Therapy

ABA Therapy

Applied behavior analysis (ABA) is the scientific approach to understanding behavior and the functional relationship between variables in the individual's environment and the targeted behavior. Data is collected and analyzed to assess the relationship between the environment and the behavior. Data is also collected to monitor progress throughout the course of therapy. The goal of ABA therapy is to target behaviors which are socially significant to the development and quality of life of each client. Therapy can include, but is not limited to targeting speech, language, school/academic readiness, social skills, play and behavior management. Treatment is individualized to the client's strengths and work to decrease skill deficits. Research has indicated that intensive ABA therapy is very effective at reducing and replacing behaviors that interfere with learning and development. ABA utilizes behavioral contingencies to help client's learn functional skills to replace undesirable behaviors.

More information about ABA, including podcasts and resources to help families understand the field and treatment, can be found at www.behaviorbabe.com or https://www.autismspeaks.org/applied-behavior-analysis-aba-0

Individualized Programing

Because we recognize that each client is unique and special, we take seriously the need to individualize his/her behavior intervention plan. Our BCBA/BCaBAs continuously assess the client's needs and utilize the most recent literature/research to support this individualized plan. Our staff (BCBAs, BCaBAs and RBTs) receive ongoing training and education to ensure we are educated in a wide range of ABA methods to meet the needs of all our clients.

Assessments We May Conduct

FBA

A Functional Behavior Assessment (FBA) is an assessment that is conducted to better understand the concern of the client/caregiver. An analyst will conduct an FBA to:

a. identify behaviors of concern in observable and measurable terms;
b. identify events/situations which predict the demonstration of target behaviors and;
c. identify what function those behaviors serve and determine alternative behaviors that can be taught.

In order to achieve this, the analyst will review records and reports, interview the client and/or caregiver, directly observe the client (in a variety of settings if appropriate) and collect and analyze data collected, develop hypotheses that describe the behavior, the situations in which they occur and the outcome, then recommend and implement interventions based upon research that supports the hypotheses. When the FBA does not produce a reliable hypothesis, additional analysis may be necessary.

VB-MAPP

Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) was created by Dr. Mark Sundberg as a means of assessing children with disabilities and other related diagnoses. The VB-MAPP is based upon B.F. Skinner's analysis of verbal behavior, ABA research and developmental milestones. Children are assessed across five domains and the results provide baseline performance and a tool for curriculum planning and a direction for intervention. This assessment is developmentally balance across verbal operants and other skills while also allowing for an assessment of barriers to learning. Other features of this assessment allow for an evaluation of the level of inclusion or group instruction a child may need (based upon the transition assessment).

ABLLS-R

Dr. James Partington created The Assessment of Basic Language and Learning Skills – Revised, which is an assessment tool, curriculum guide and skills tracking system use to help guide language instruction and other critical learner skills for children with autism or other developmental disabilities. This criterion referenced assessment contains an outline of many skills necessary to learn and communicate successfully. This assessment also provides baseline performance and serves as a tool for curriculum and intervention planning.

AFLS

The Assessment of Functional Living Skills (AFLS) is an assessment, created by Dr. James Partington, which assesses individuals using a skills tracking system and curriculum guide for developing the essential skills for independent and functional living. This tool creates a baseline performance and offers a progressive track for the development of these essential skills. Skills targeted consist of those necessary for work, community and family settings and participation.

Other assessments may be used based upon the individual needs of the client.

Behavior Intervention Plans

Behavior Intervention Plan (BIP) is a plan of intervention created based upon the behavior analyst's assessments and the existing literature. A behavior plan will address the client's present baseline level of skill and outline specifically short- and long-term goals. These goals are reached via addressing behaviors to increase and behaviors to decrease. With each behavior we look to decrease, we will look to teach/increase at least one other skill that will fill the same function for the individual. Behavior plans are emphasized using reinforcement rather than the use of punishment-based procedures.

Each behavior intervention plan written is specifically tailored to the client's goals, needs and strengths and weaknesses.

Staffing

Each client will have a Board Certified Behavior Analyst (BCBA) or Board Certified assistant Behavior Analyst (BCaBA) as the lead supervisor for his/her treatment. A Registered Behavior Technician (RBT) will provide direct (1:1) therapy in the clinic or school setting. All therapists are certified through the Behavior Analyst Certification Board.

Parent Guidelines

We recognize the importance of working with you toward the achievement of the goals for your child. We want to ensure that our communication is open so that we may continue to work toward these goals. Please communicate any questions, comments or concern you have at any time.

We request that families give us at least two weeks' notice on significant changes in their plans for ABA therapy to help facilitate consistency in therapy. This notice will allow for fading and/or transitioning therapy.

Parents and therapists should be respectful and courteous to each other. Open communication between parents and therapists is essential to the establishment of a successful program for the child. If there are any problems or concerns, please contact the office (additional information available in the grievance section of this handbook).

Because it is always important that our attention be with the client, we request that all communication go through the office or staff email. We can always schedule a meeting to discuss questions/comments/concerns that are not appropriate for phone or email. In the event of an emergency, our office will notify us immediately. Communication with employees via personal cell phones or any social media outlet is not permitted.

We understand that there may be times when you would like to show your child's therapist your appreciation; however, the board that oversees our certification prohibits our RBTs, BCaBAs, and BCBAs from accepting gifts.

Please understand that all information shared is HIPPA protected, it is essential that every ABA clinic employee respects and maintains each client's right to confidentiality regarding his/her treatment and all personal information. All HIPPA laws apply.

Service Agreement and Consent Form

This packet contains information about our services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI used for the purpose of treatment, payment, and health care operation). HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires we obtain your signature acknowledging we have provided you with this information. Although these documents are long and sometimes complex, it is very important you read them carefully and you ask questions regarding the procedures. When signing this document, it will also represent an agreement between our clients/caregivers and the ABA Clinic at Beyond the Spectrum. You may revoke this agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed by your health insurer to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations. If you have any questions or concerns, please feel free to bring them to our attention.

Services and Discharge

The ABA Clinic at Beyond the Spectrum offers an individualized ABA program. To determine the program needed for each client, we initially complete an assessment to determine whether the client would benefit from our services. When it is determined that our services are needed, a BCBA will continue to work with you and develop a behavior plan based on the findings of the assessment and existing research.

The behavior plan includes general and specific goals with time frames for mastery; goals are reassessed every 6 months. The behavior plan is then implemented by the BCBA who supervises Registered Behavior Technicians on proper implementation of the treatment plan, data collection and ensures for fidelity. The behavior plan is ajusted as needed based upon client progress toward goals; decreasing criteria if too challenging or expanding goals which are found to be too easy. If, after adjusting the treatment plan and following the updated plan we may determine our services are not the proper treatment for the client. If such a determination is made, we will follow our discharge and referral protocol.

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

To Protect the Client or Others from Harm

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

Confidentiality, Records, Release of Information and Professional Consultatio

Services are best provided in an atmosphere of trust; because of this, all services are confidential except to the extent that we are provided with written authorization to release specified information to specific individuals/agencies.

Behavior Analysts routinely consult about cases with other professionals. In doing so, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal. We will inform clients of these consultations. If you want us to talk with or release specific

information to other professionals with whom you are working, you will need to sign an authorization specifying what information can be released and with whom it can be shared.

Billing and Payment

Changing Fee Structure

The fee structure for all services rendered through the ABA Clinic at Beyond the Spectrum is subject to change. Clients will be made aware of such modifications 30 calendar days prior to the effective day of any change.

We accept cash, check or credit card for payments. Invoices are billed monthly. Payment is expected by the end of the billed month. If payment cannot be made or you have any billing/payment questions, please contact Peggy Caruso at peggy.caruso@beyondthespectrum.org. A credit card must be on file before initiation of services (unless client has Medicaid).

Professional Records

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

Patient's Rights

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

Contacting Us

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

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

Child's Name	Date
Parent/Guardian Printed Name	Parent/Guardian Signature

THE ABA CLINIC AT BEYOND THE SPECTRUM
REGISTRATION FORM AND FAMILY QUESTIONNAIRE

NAME: _____ DOB: _____

ADDRESS: _____

_____

SEX: ____M ____F PERSON RESPONDING: _____

PHONE NUMBER: _____

EMAIL: _____

PREFERRED WAY OF CONTACT: PHONE EMAIL TEXT OTHER

LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME: _____

MEDICAL DIAGNOSIS:

DIAGNOSIS	DIAGNOSING PHYSICIAN	DATE DIAGNOSED

ALLERGIES: _____ ___

SPECIAL DIET/GI ISSUES: _____ _____

SKIN CONDITIONS/ ASTHMA/ SEIZURES: _____

SLEEP: DOES YOUR CHILD SLEEP THROUGH THE NIGHT? _____ DOES YOUR CHILD NAP? _____

MEDICATION:

MEDICATION	DIAGNOSING PHYSICIAN	DOSAGE	TIME GIVEN

PRIMARY GOALS FOR ABA

1. _____
2. _____
3. _____

PRIMARY CAREGIVERS:

NAME	RELATIONSHIP	PHONE NUMBER

LIVING ARRANGEMENT:

NAME	AGE	RELATIONSHIP

BIRTHING HISTORY/MEDICAL HISTORY/ SURGERIES/HOSPITALIZATIONS:

_____

_____

_____

PROGRAM AND SERVICES:

SERVICE	PROVIDER	FREQUENCY HOURS/WEEK	DATES OF SERVICE
SCHOOL			
ABA (PREVIOUS OR CURRENT)			
OT			
PT			
SPEECH			
MUSIC			
RESPITE			
CAMP			
OTHER			

PLEASE LIST ANY POSSIBLE SIGNIFICANT EVENTS YOUR CHILD MAY HAVE EXPERIENCED (E.G. DIVORCE, MOVES, ABUSE, BIRTH OF SIBLINGS, SUBSTANCE ABUSE, TRAUMATIC EVENTS, CUSTODY ISSUES) _____

_____

_____

HOW DOES YOUR CHILD COMMUNICATE NEEDS? _____

_____

DOES YOUR CHILD REFUSE ANY HYGIENE CARE OR ROUTINES (E.G. HAIR BRUSHING, BATHING, BRUSHING TEETH, CLIPPING NAILS, DOCTOR OR DENTAL VISITS? _____

_____

_____

DOES YOUR CHILD HAVE ANY SENSORY CONCERNS (NOISE, TEXTURES, ETC.) _____

_____

_____

DESCRIBE YOUR CHILD'S ABILITY TO DO THE FOLLOWING:

LABEL ITEMS: _____

IMITATE OTHERS: _____

ENGAGE WITH PEERS: _____

PLAY WITH TOYS AS INTENDED: _____

RESPOND TO VOCAL DIRECTIVES: _____

ACADEMIC ABILITY: _____

_____

DOES YOUR CHILD RESPOND TO THEIR NAME? _____

IS YOUR CHILD TOILET TRAINED? _____

CAN YOUR CHILD DRESS INDEPENDENTLY? _____

DOES YOUR CHILD EAT MEALS AT TABLE? USE UTENSILS? _____

DO YOU HAVE ANY CONCERNS IN THE COMMUNITY OR GOING OUTSIDE THE HOME? _____

CAN YOUR CHILD SWIM? _____

DOES YOUR CHILD HAVE AWARENESS OF DANGER? _____

DOES YOUR CHILD HAVE BEHAVIOR CONCERNS AT SCHOOL? _____

DOES YOUR CHILD HAVE SPECIFIC BEHAVIOR CONCERNS SUCH AS: AGGRESSION, MOUTHING, ELOPEMENT, SELF-INJURY, PROPERTY DESTRUCTION, CLIMBING, THROWING, TANTRUMS, ETC.)

BEHAVIOR	WHAT DOES IT LOOK LIKE	HOW OFTEN IN A DAY?

IF RESPONDING YES TO THE FOLLOWING PLEASE PROVIDE A COPY:

DOES YOUR CHILD HAVE AN FBA FROM SCHOOL? _____

DOES YOUR CHILD HAVE AN IEP? _____

DOES YOUR CHILD HAVE A BIP FROM ANOTHER ABA PROVIDER? _____

WHAT ARE YOUR CHILD'S FAVORITE TOYS, FOODS, ITEMS, ACTIVITIES?

_____

_____

_____

_____

PLEASE EXPLAIN ANY ROUTINES/STRUCTURE/ORGANIZATION YOU CURRENTLY HAVE IN PLACE

_____

_____

_____

_____

PLEASE SHARE ANY CUSTOMS, RELIGIOUS BELIEFS, CULTURAL NORMS THAT MAY IMPACT TREATMENT:

_____

_____

EMERGENCY INFORMATION AND CONTACTS

Client's Name: _____ DOB: _____

Address: _____

Diagnosis: _____ Allergies: _____

Other Medical Conditions: _____

Current Medications: _____

Primary Emergency Contacts:

Parents Name: _____
Address if different from above: _____
Cell Phone: _____
Email Address: _____

Parents Name: _____
Address if different from above: _____
Cell Phone: _____
Email Address: _____

Additional Emergency Contacts

Name: _____ Phone: _____
Address: _____ Relation: _____
Name: _____ Phone: _____
Address: _____ Relation: _____

I give permission for the following people to pick up my child (Only add people not listed above)

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

1) No child will be released to any person whose name does not appear on this Authorization Pick-Up List
2) Before any person can remove a child, proper ID, such as a current driver's license, must be shown
3) If there is ever any question as to the identification of any person attempting to remove a child from the premises, the legal guardian will be notified immediately
4) The legal parent/guardian must give advanced written authorization before any person not appearing on our Authorized Pick-Up List will be allowed to remove a child from the premises
5) In the event of an emergency, the legal parent/guardian may give above stated permission verbally, but only if given directly to the Administrator or authorized office personnel.

Beyond the Spectrum defines legal parents or legal guardian to be person(s) who enrolled the child and whose signature is indicated at the bottom of this form. In the case where a divorce or legal separation has occurred or is in the process, legal court documentation must be presented as proof of who is awarded temporary or permanent custody of the child in question. The safety of the minor child in our custody will always take top priority in any situation. Only official court documents, whose authenticity has been verified will supersede any other documents received or placed on file.

FORM COMPLETED BY: _____ SIGNATURE: _____

CLIENT NOTIFICATION OF PRIVACY OF RIGHTS
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) NOTICE OF PRIVACY PRACTICES

This Notice of Private Practice describes how the ABA Clinic at Beyond the Spectrum may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information that may identify you and that related to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of PHI - Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to may your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment - We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a home health agency that provides care for you or shared with a physician to whim you have referred, to ensure that the physician has the necessary information to diagnose or treat you.

Payment - Your PHI will be used, as necessary, to obtain payment for your health care services. For example, obtaining approval for therapy services that may require that your relevant PHI be disclosed to obtain approval for the approved therapy services.

Healthcare Operations - We may use or disclose, as is necessary, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training or medical students, licensing and conducting or arranging for the other business activities. For example, we may disclose your PHI to medical school students that see patients at our office or we may use sign-in sheets at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the lobby when you are waiting to see your physician. We may use your PHI to contact you to remind you of your appointment.

Your PHI may be used in the following situations with or without authorization. These situations include: as required by law, public health issues as required by law, communicable disease, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, criminal activity, workers compensation, required uses and disclosures: under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164-500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization at any time in writing, except to the extent that your provider or the ABA provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to a family member or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices, your request must state that specific restrictions requested and to whom you want to restrictions to apply.

HIPPA and Service Agreement 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 HIPPA notice described above or have been offered a - and declined. Consent by all parents/legal guardians is required.

Printed name of responsible party

Signature of responsible party and Date

Authorization to Bill Insurance

Client Name: _____ DOB: _____

I _____, hereby give my consent for the ABA Clinic at Beyond the Spectrum to bill my/my child's insurance carrier for the services rendered to my child by the above-mentioned provider. In addition, I agree to pay the ABA Clinic at Beyond the Spectrum any deductible or uncovered charge in accordance with my health care plan including the assessment fee if I choose not to proceed with services provided by the ABA clinic at Beyond the Spectrum.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

Authorization to Release Medical Information to Insurance Carrier

I understand that my express consent is required to release any health care information relating to assessment and treatment. I, _____, hereby give my consent for the ABA Clinic at Beyond the Spectrum to release medical and all other relevant information to our insurance carrier as required by my insurance carrier to process medical billings.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

STATEMENT OF AUTHORITY TO CONSENT

Client Name: _____ Client DOB: _____

I certify that I have the authority to legally consent to assessment, release of information, and all legal issues involving the above-named individual. Upon request, I will provide the ABA clinic at Beyond the Spectrum with the proper documentation to support this claim. I further hereby agree that if my status as legal guardian should change, I will immediately inform the Analyst of this change in status and will further immediately inform the Analyst of the name, address, and phone number of the person(s) who have assumed guardianship of the above-named individual.

I also consent release to contact the following named people in order to discuss relevant information pertinent to intervention: (provide name and phone number).

1. _____
2. _____
3. _____

Parent/Guardian: _____ Date: _____

TREATMENT CONSENT FORM FOR ABA SERVICES

I consent for behavioral treatment to be provided for the above-named individual by the ABA clinic at Beyond the Spectrum. I understand that the procedures used will consist of manipulating antecedents and consequences to produce improvements in behavior; however, at the beginning of treatment behavior may get worse in the environment where the treatment is being provided or in other settings. As part of the behavioral treatment, physical prompting and manual guidance may be used. The actual treatment protocols, which will be used, have been explained to me.

Parent/Guardian: _____ Date: _____

Individual/Caregiver and Provider Contract

1. I understand that once the behavior program is developed, it will be up to me and the therapists to implement the majority of the intervention.
2. I understand that I may need to change some house/family routines to improve the individual's behavior.
3. I agree to take data on the individual's behavior as requested.
4. I understand that in order for this intervention to be successful, I may be required to put forth individual effort.

Parent/Guardian: _____ Date: _____

Confidentiality Act/ Abuse Reporting Protocol

Client Name: _____

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

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

Parent/Guardian: _____ Date: _____

GRIEVANCE/ DISCHARGE PROCEDURE

Grievance: If you are not satisfied with the services you receive from the staff assigned to you, please first call the behavior analyst assigned to your case. If you have a grievance with the BCBA/BCaBA/RBT or are not satisfied with the manner in which your concerns are being addressed, you may file a grievance directly with the Behavior Analyst Certification Board (BACB). If the issue is not resolved, the services may be terminated.

Discharge: The behavior analyst reserves the right to discontinue or discharge treatment in the instances of:

1. Any parent or caregiver that refuses to follow a treatment plan and has been reminded of the contract they signed stating that it is indeed the family's responsibility to follow a plan.
2. Any child who ages out of coverage (22 yrs. and no longer in school)
3. Any individual that is not improving in spite of exhausting all known interventions, procedures, and or research-based strategies.
4. Goals have been met and maintained; therapy faded.
5. Violation outlined in the Cancellation/No Show Policy
6. Failure to pay for services.

If an individual is discharged, it is best practice that the analyst provide a list of other providers and professionals in their area with the background and expertise to provide support services to the individual and their family.

Disclaimer: The analyst will in no way turn down a family for coverage, nor will they discharge or discontinue treatment on the basis of race, creed, sexual orientation, wealth, etc.

I understand the Grievance and Discharge Policies. An analyst has taken the time to explain these to me.

Parent/Guardian: _____ Date: _____

CANCELLATION/ NO SHOW /CHANGE IN APPOINTMENT POLICY

Individual: _____

Regular attendance is required for our services to be effective. Irregular attendance costs both the assigned staff and the overall program time and money. It is therefore the responsibility of the individual and or his/her legal guardian to attend all scheduled appointments.

Changes in Schedule - If there is a change in schedule such as an appointment, but the student will still be attending the clinic for part of the scheduled session, please provide a written notice. The written notice needs to be sent to the program director at least 24 hours prior to the start of the day. Without this alert there is a chance that your child may not be able to receive the one-on-one therapy due to staff availability. This includes early dismissals that were not scheduled prior. Changes in schedule that are not communicated 24 hours in advance will incur a $25 cancellation/change in schedule fee.

Late Arrivals - If there is an unexpected situation and you are going to be late dropping off your child, please call/text the program director directly. If the parent does not give the program director a written notice at least 12 hours prior to the session, it is considered a "late arrival". The ABA Clinic at Beyond the Spectrum gives the parent one hour from the student's scheduled start time before cancelling the session. After one hour, the session will be cancelled at a $75 cancellation fee. This is to better assist with over-staffing. If you are more than 15 minutes late for any reason and have not contacted the center director, you will be changed for delay at a charge of $1/minute after 15 minutes. This will cover the costs or the assistant who arrived on time to work with your child. Repeated tardiness will be tracked. If this becomes a concern, you may be asked to change your child's therapy time to a later session time.

Repeated tardiness is defined as being late for your session (more than 15 minutes) 2x/month. If you exceed twice a month being tardy even with alerting the center director, and you continue to be late, You will incur a fee of $1/minute after the 15 minutes. You are always welcome to push back your child's session time on a consistent basis if you are unable to make your scheduled start time.

No-Show Policy - Should a child miss therapy with no previous call from the family to the program director or analyst, the parents will be charged a **$75 no-show fee**. If a child is more than one hour late with no phone call to give notice to the therapist, the no-show late fee will still apply and the session may or may not be provided based upon staff availability. If you are late for your child's session, your child's session time will still end at the scheduled end time. Additional minutes will **not** be added to the end of the session.

I understand these cancellation/no show/ service delivery policies and agree to its terms.

Client of Legal Age: _____ Date: _____

Parent/Guardian: _____ Date: _____

PERMISSION TO PHOTOGRAPH

Client's Name: _____ DOB: _____

I give permission and consent for The ABA Clinic at Beyond the Spectrum to photograph for the following purposes:

- ☐ Crafts/Clinic Projects
- ☐ Educational training presentations
- ☐ Promotional marketing materials
- ☐ Social media
- ☐ Other: _____
- ☐ None, please no photos

_____ _____

Parent/Guardian Printed Name Parent/Guardian Signature

Date: _____

PERMISSION TO VIDEOTAPE OR AUDIOTAPE

I give permission and consent for the ABA Clinic at Beyond the Spectrum to videotape and/or audio tape my child during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Beyond the Spectrum.

_____ _____

Parent/Guardian Printed Name Parent/Guardian Signature

Date: _____

FINANCIAL RESPONSIBILITY

For Clients Without Insurance or Active Authorizations:

- No Insurance? Clients without insurance should pay every two weeks. You'll get an invoice, and it should be paid within 14 days.
- No Active Authorization? If you don't have an active authorization, any charges you incur outside the authorized period are your responsibility. You might be able to get reimbursed from your insurance if they eventually approve the services, but we'll still charge the out-of-pocket rate.

For Insured Clients:

- Got New Insurance? If your insurance changes, let us know and provide us with your new card. Remember, when insurance switches, sometimes services need to be re-assessed, and a new behavior plan might have to be submitted. This is important to ensure there's no gap in your child's treatment.
- Check Our Network Status: Always make sure we're still an "in-network" provider with your insurance. We'll do our part by submitting necessary forms and billing secondary insurances if needed.

For HMO or Managed Care Plan Clients:

- Your Share: You're responsible for any co-payments or parts of charges that your plan says you must pay.
- Payments: You'll get an invoice by mid-month, and any copayments or deductible balances should be paid by the start of the next month. Our financial director will charge your saved card on the 1st for the invoice balance.
- Referrals: If your insurance requires referrals for treatments, make sure we have it when you come for therapy. If we don't have the needed referral, we might need to reschedule or you could be responsible for the charges.
- Unresolved Balances: If there's a remaining balance that isn't resolved, either through full payment or a payment plan, and you decide to stop services, we might have to send your account to an outside collection agency.

For in-Network Plan Clients:

- Your Share: Like the HMO clients, you're responsible for any co-payments or parts of charges that your plan dictates.
- Non-Covered Services: If there are services that your insurance doesn't cover, they're your responsibility. Please pay in full when you get the invoice. If you have questions about what's covered, reach out to your insurance's member services department.

Remember, we're here to help. If any part of this is unclear, or you're facing financial challenges, please speak to us. We're dedicated to ensuring that your child receives the care they need.

Notification of Benefits and Credit Card on File

- I have read and understand my notification of benefits. I have been provided a copy for review and have had the opportunity to ask questions for clarification as needed.
- I agree to keep a credit card on file to be charged at the first of the month for any outstanding invoices.

FES Scholarship Payments

- If a family has FES funding, the family is responsible for any out of pocket, deductible or invoice payments paid directly to Beyond the Spectrum upon invoice date. It is the responsibility of the family to submit for reimbursement through FES. Beyond the Spectrum is not responsible for invoices not reimbursed through FES.

Remember, we're here to help. If any part of this is unclear, or you're facing financial challenges, please speak to us. We're dedicated to ensuring that your child receives the care they need.

Signed this _____ day of _____, 20____

_____ _____

Printed name of responsible party Signature of responsible party

Credit Card Authorization Form
ABA Clinic/Beyond the Spectrum

Name on the Card: _____

Type of Card: Visa ☐ MC ☐ AmEx ☐

Account Number _____

Expiration Date _____

Security Code _____

Billing Address _____

City, State, Zip _____

Phone Number _____

Your card will be charged for the total amount on your statement on the first of each month.

By signing this form, you authorize Beyond the Spectrum **to charge your card for the amount listed above.**

Signed: _____ Date: _____

Beyond the Spectrum
7333 International Place
Sarasota, Fl 34240
(941) 907-3443

SEIZURE PLAN

ONLY COMPLETE IF YOUR CHILD HAS A SEIZURE DISORDER

Client Name: _____ DOB: _____

EMERGENCY CONTACT: _____ PHONE: _____

Seizure Information

Seizure Type	What Happens	How Long Does it Last	How Often Does it Occur

Triggers: _____

_____

Daily Seizure Medicine

Medicine Name	Dose	How/When Administered

Seizure First Aid	Call 911 if. . .
☐ Keep calm, provide reassurance, remove bystanders	☐ Generalized seizure longer than 5 minutes
☐ Keep airway clear, turn on side if possible, nothing in mouth	☐ Two or more seizures without recovering between seizures
☐ Keep safe, remove objects, do not restrain	☐ As needed treatments don't work
☐ Observe and record time and duration	☐ Injury occurs or is suspected, or seizure occurs in water
☐ Other care as needed: _____	☐ Breathing, heart rate or behavior doesn't return to normal
	☐ Unexplained fever or pain, hours or few days after a seizure
	☐ Other care needed: _____

When Seizures Require Additional Help

Type of Emergency (long, clusters or repeated events)	Description	What to Do

Health Care Contact

Epilepsy Doctor:	_____	Phone:	_____
Preferred Hospital:	_____	Phone:	_____
Primary Care:	_____	Phone:	_____

Special Instructions:

_____ _____

Parent/Guardian Signature Date

MEDICATION ADMINISTRATION IN CLINIC

ONLY COMPLETE IF YOUR CHILD WILL BE TAKING MEDICATION DURING ABA SESSION TIMES

Name: _____ DOB: _____

The parent/guardian of _____ ask that school/child care staff give the following medication _____ (name and dose) at _____ (time(s)) to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication. The parent agrees to pick up expired medication within one week of notification by staff.

Prescription medications must come in a container labeled with the child's name, name of medication, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. The pharmacy's name and phone number must also be included on the label.
Over the counter medication must be labeled with the child's name. dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medicine with the nurse or school staff delegated to administer medication.

Signed this ____ day of _____, 20__

_____ _____
Printed name of parent/guardian Signature of parent/guardian

_____ _____
Work Phone Home/Cell Phone

****

HEALTH CARE PROVIDER AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL OR CHILD CARE

Child's Name: _____ DOB: _____
Medication: _____ Dosage: _____
Route: _____ Administered at the following time(s): _____
Special instructions: _____
Purpose of medication: _____
Side effects that need to be reported: _____
Starting date: _____ Ending Date: _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority License Number

_____ _____
Phone Number Date

Please ask the pharmacist for a separate medicine bottle to keep at the ABA clinic
Thank you!

EMERGENCY & NON-EMERGENCY MEDICAL CONSENT FORM
Consent for Responding to Medical Emergencies

As the parent or legal guardian of _____, I understand and acknowledge the following (please read and initial next to each of the sections below:

Non-Emergency/Less Critical Situations: In the event that my child suffers a minor injury or illness, such that basic first-aid techniques are required but not to the extent that they require emergency medical personnel (ex. isolated instances of vomiting; minor scrapes and cuts), trained staff will administer basic first-aid, an incident report will be documented as soon as possible and I (the parent/guardian indicated as first emergency contact) will be notified as soon as possible by a clinic supervisor.

EMERGENCY NOTIFICATION PREFERENCE – Please identify which of the following options you would prefer in the case of a medical emergency:

____ Call 911/Emergency Medical Services first, then notify me (the parent/guardian indicated as first emergency contact).

____ Notify me (the parent/guardian indicated as first emergency contact) first, then call 911 if parents/guardians cannot be reached immediately.

Emergency Notification: Emergency contacts for my child will be contacted by the order in which they are provided. I understand that, in the case of a medical emergency, a clinic supervisor at The ABA Clinic at Beyond the Spectrum will make reasonable efforts to contact all emergency contacts, in the order they are written, until one is reached, using the contact information provided.

Emergency contact #1: Name: _____Phone: _____

Emergency contact #2: Name: _____Phone: _____

Emergency contact #3: Name: _____Phone: _____

Emergency contact #4: Name: _____Phone: _____

Emergency Situations: In the event that my child suffers an injury, critical illness or medical episode (including, but not limited to, seizures, respiratory distress, allergic reactions, events that lead to loss of consciousness or any unforeseen medical emergencies which require the attention of emergency medical personnel) while at The ABA Clinic at Beyond the Spectrum, the clinic staff will take necessary steps to ensure the

safety and health of my child. An incident report will be documented as soon as possible and I will be notified as soon as possible by a clinic supervisor (see below).

Emergency Medical Services: I hereby consent for The ABA Clinic at Beyond the Spectrum staff to call 911 and contact emergency medical services in the event of a significant medical emergency involving my child. This includes the administration of first-aid or CPR or the use of an AED if deemed necessary by and administered by certifiably trained staff.

Preferred hospital (if any), with address to Emergency Department included:

_____

_____

Transportation in Case of Medical Emergency: While the clinic will attempt to transport my child to the preferred hospital, I understand that in certain emergency situations, the nearest hospital might be chosen based on the discretion of the emergency medical personnel. The nearest hospital with an emergency room to the ABA Clinic at Beyond the Spectrum is as follows at each of our locations:

Lakewood Ranch –

1. Lakewood Ranch Medical Center 8330 Lakewood Ranch Blvd. Lakewood Ranch, FL 34243– *1.7 miles away*
2. ER at Fruitville - 6760 Fruitville Rd.,Sarasota, FL 34240– *4.7 miles away*

Port Charlotte –

1. Bayfront Health Port Charlotte 2500 Harbor Blvd, Port Charlotte, FL - 2.9 miles
2. Fawcett Memorial – 21298 Olean Blvd, Port Charlotte, FL - 3 miles

Incident Report: In the case of any medical attention being provided, non-emergency or emergency, an incident report will be documented as soon as possible. A copy of all incident reports will be made for the possession of any of the individuals listed below upon request. The following individuals (first and last name) may receive a copy of any incident report pertaining to medical attention provided to my child upon request:

_____

_____

____ **Understanding of Rights:** I understand that I may ask for clarification of my rights at any point while my child is an active client of The ABA Clinic at Beyond the Spectrum. I have read all of the above points clearly before providing my consent.

Parent/Guardian's Name (Printed): _____

Parent/Guardian's Signature: _____ **Date:** _____

CANCELLATION/ NO SHOW /CHANGE IN APPOINTMENT POLICY

Individual
:

Regular attendance is required for our services to be effective. Irregular attendance costs both the assigned staff and the overall program time and money. It is therefore the responsibility of the individual and or his/her legal guardian to attend all scheduled appointments.

Changes in Schedule, Late Arrivals, Late Pick Ups - If there is a change in schedule such as an appointment, but the client will still be attending the clinic for part of the scheduled session, please provide written notice. The written notice needs to be sent to the scheduling manager at least 24 hours prior to the session schedule change. Without this alert there is a chance that your child may not be able to receive the one-on-one therapy due to staff availability. This includes early dismissals that were not scheduled prior. Changes in schedule that are not communicated 24 hours in advance may risk availability of your child's therapist and a session for that day. Repeated schedule changes that are not communicated risk your child being placed back on our waitlist.

If there is an unexpected situation and you are going to be late dropping off your child, please email the scheduling manager directly. The ABA Clinic at Beyond the Spectrum gives the parent 30 minutes from the student's scheduled start time before cancelling the session. After 30 minutes, the session will be cancelled. Repeated tardiness will be tracked. If this becomes a concern, you may be asked to change your child's therapy time to a later session time.

Repeated tardiness is defined as being late for your session (more than 15 minutes) 2x/month. If you exceed twice a month being tardy even with alerting the center director, and you continue to be late, Your child may be placed back on our waitlist.

No-Show Policy - Should a child miss therapy with no previous call from the family to the scheduling manager, the parents will be documented with a no call/no show. 3 documented no call no shows may place your child's services on hold and your child will be placed back on our waitlist.

If your child attends school, it is your responsibility to inform both the school and the ABA clinic that your child will be late/out/picked up early.

I understand these cancellation/no show/ service delivery policies and agree to its terms.

Parent/Guardian: _____ Date: _____