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 registration 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 or mail them to the address above, together with a copy of your insurance card(s), front and back and the prescription for ABA Services (if these have not already been provided), as well as a diagnosis report stating an autism spectrum diagnosis, a copy of your child's IEP, Psych evaluation and any other pertinent information that will help qualify your child for ABA services.

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

Sincerely,

Amy Labrie, MS, BCBA

PLEASE COMPLETE THE FOLLOWING:

_____ Review and keep parent handbook, Calendar, HIPPA & Client rights.
_____ Initial & Annual consent to participation
_____ Initial Registration form
_____ Confidentiality Act/ Abuse Reporting Protocol
_____ Grievance/Discharge Policy
_____ Activity Participation and Transportation Release
_____ Permission to photograph
_____ Cancellation/No Show Policy
_____ Individual / Caregiver and Provider contract
_____ Authorization to Discuss Information
_____ Statement of authority to consent
_____ Consent to participate in Assessment and Records release
_____ Financial Responsibilities
_____ Authorized Pick-up and client release
_____ Medication treatment authorization
_____ Medication Authorization of Over-The-Counter Medications
_____ Medication Authorization of Over-The-Counter Medications (Middle/High School ONLY)

CLINIC RESPONSIBILITY

1. Clinic to obtain pre-approval from insurance company (if applicable) is required prior to any evaluation, therapy, or other service.

2. Parents Meeting to tour clinic and review intake process and procedures/policies.

3. Intake conducted by BCaBA/BCBA (may take 4+ observations/meetings to conduct)
    - Parent Meeting/Interview as part of the FBA
    - Assessment that is appropriate for your child (VB-MAPP, ABLLS, AFLS, etc.)

4. Behavior plan submitted to insurance company for approval.

5. Parent meeting to review reports and discuss goals, treatment plan and schedule.

6. The majority (at least 75%) of direct therapy will be conducted by a Registered Behavior Technician (RBT) who has been trained by the Analyst. The RBT will continue to receive ongoing supervision by the Analyst. The Analyst will provide up to 25% of direct therapy.

7. Monthly staff meetings to review progress.

8. Biannual assessments to evaluate progress and update behavior plan.

PHILOSOPHY

At Beyond the Spectrum we believe that every child deserves to be loved and accepted for who they are. We are here to support both the children and families of our community who are affected by Autism and other related disorders. Let us show how the culture at Beyond the Spectrum can change your child's life.

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 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 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 this 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) receiving ongoing training and education to ensure we are educated in a wide range of ABA methods as 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 operands 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.

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 for 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. Please do not ask about other clients' program or treatment, as this information will not be discussed and could possibly lead to the dismissal of your student from the program.

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 implantation 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 CONSULTATION

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.

PAYMENTS

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

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 problems or concerns; assessment, consultative, or therapeutic goals; progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. 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

Parent handbook Consent

Your signature(s) below indicates that you have read, understood, and agree to the terms of this Parent Handbook.

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

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

This notice describes how medical information about you may be used and disclosed and how you can get access to this information, please review it carefully.

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 her 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, coroners, funeral directors, organ donation, research, criminal activity, national security, workers compensation, inmates, 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 from described above or have been offered a copy and declined. Consent by all parents/legal guardians is required.

Signed this ___ day of _____, 20__

_____ _____

Printed name of responsible party Signature of responsible party

_____ _____

Printed name of witness Signature of witness

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.

_____ _____

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

THE ABA CLINIC AT BEYOND THE SPECTRUM
REGISTRATION FORM

CLIENT INFORMATION

Address: _____

_____

Social Security No: _____

Gender: M ☐ F ☐ Date of Birth: _____

PARENT/GUARDIAN INFORMATION

Mother's Name: _____

Address (if different): _____

_____

Date of Birth: _____ Social Security No.: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Father's Name: _____

Address (if different): _____

_____

Date of Birth: _____ Social Security No.: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

INSURANCE COVERAGE:

Policy Holder: _____

Insurance Carrier: _____

Insurance Policy No.: _____

Insurance Group No.: _____

SIBLING/HOUSEHOLD MEMBERS (OTHER THAN PARENT/GUARDIAN)

Name: _____

Date of birth: _____ Relationship to client: _____

Name: _____

Date of birth: _____ Relationship to client: _____

Name: _____

Date of birth: _____ Relationship to client: _____

Name: _____

Date of birth: _____ Relationship to client: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: _____
Relationship to child: _____

Name: _____ Phone Number: _____
Relationship to child: _____

OTHER SERVICES PROVIDED (SPEECH/PT/OT, FEEDING THERAPY, ETC.)

Name of Provider: _____
Services provided: _____ Frequency (times per week) _____

Name of Provider: _____
Services provided: _____ Frequency (times per week) _____

Name of Provider: _____
Services provided: _____ Frequency (times per week) _____

DIAGNOSIS

Primary diagnosis 1: _____
Date of diagnosis: _____ Diagnosing professional: _____

Primary diagnosis 2: _____
Date of diagnosis: _____ Diagnosing professional: _____

Primary diagnosis 3: _____
Date of diagnosis: _____ Diagnosing professional: _____

Medical conditions (if applicable): _____

Allergies: _____

Special diet information: _____

CURRENT MEDICATION(S)

Medication	Dose	Frequency	Prescribing Provider

ABA Services Requested

☐ School 1:1 therapy during entire/partial school day at BTS

☐ Clinic 1:1 therapy at clinic only

☐ School & Clinic 1:1 therapy at both school and clinic locations

Are there days or times when your student is not available for therapy? If yes, when? ____________________

____

What are your goals for your student's ABA therapy? Please include social, communication, etc. ____________________

____

____

____

____

Problem Behaviors

Behaviors of concern: What does your child say or do that concerns you the most (e.g., aggression towards self or others, property destruction, tantrums, screaming, inappropriate interactions, resistance, off-task behaviors, substance abuse, sexual behavior)? Estimate how often, long, and severe.

Behavior (please describe)	Frequency (hourly, daily, weekly, less often, more often, etc.)	Duration (how long does the behavior occur)	Description
	☐ Hourly ______ ☐ Daily ______ ☐ Weekly ______ ☐ Other ______	☐ Seconds ______ ☐ Minutes ______ ☐ Hours ______	
	☐ Hourly ______ ☐ Daily ______ ☐ Weekly ______ ☐ Other ______	☐ Seconds ______ ☐ Minutes ______ ☐ Hours ______	
	☐ Hourly ______ ☐ Daily ______ ☐ Weekly ______ ☐ Other ______	☐ Seconds ______ ☐ Minutes ______ ☐ Hours ______	
	☐ Hourly ______ ☐ Daily ______ ☐ Weekly ______ ☐ Other ______	☐ Seconds ______ ☐ Minutes ______ ☐ Hours ______	
	☐ Hourly ______ ☐ Daily ______ ☐ Weekly ______ ☐ Other ______	☐ Seconds ______ ☐ Minutes ______ ☐ Hours ______	

____

What situations are these behaviors LEAST likely to occur? _____

What typically happens *immediately* before the behavior(s)? _____

What typically happens *immediately* after the behavior(s)? _____

What current treatments are being implemented? _____

What treatments have been implemented previously? _____

What motivates or interests your child? _____

BEHAVIORAL LANGUAGE ASSESSMENT
EXPRESSIVE VERBAL SKILLS

Describe your child's spontaneous language: _____

Describe how your child indicates what she/he wants or needs: _____

Describe the type of items your child asks for: _____

Describe your child's ability to label items, events or actions: _____

Describe your child's ability to answer questions: _____

Is your child conversational? Please describe. _____

Receptive Language Skills

Describe your child's ability to follow directions and routines within context or with a model: _____

Describe your child's ability to follow directions and routines which are out of context or without a model: _____

Is your child able to select an item from a field of two or more when given the description of the item? _____

Motor Imitation

Is your child able to imitate simple motor movements such as clapping, waiving, etc.: Y ☐ N ☐

Is your child able to imitate actions using objects (i.e. "do this" modeling action)? Y ☐ N ☐

Does your child make eye contact? Y ☐ N ☐

If yes, with whom? Mom ☐ Dad ☐ Siblings ☐ Familiar People ☐ Others ☐

Describe your child's interest in doing what others are doing: _____

Describe your child's ability to participate in turn taking activities: _____

Does your child fixate on certain topics? If yes, please describe. _____

Play Skills

Describe how your child plays with toys (including the type of toy and how long): _____

Does your child use toys are they are intended? _____

Describe how your child plays with other children: _____

Describe how your child engages in imaginative and pretend play: _____

SELF-HELP SKILLS

How does your child feed him/herself: _____

Is your child toilet trained? Yes ☐ No ☐

Does your child dress independently? Yes ☐ No ☐ Describe: _____

Describe how your child responds to dangerous situations: _____

What else would you like us to know about self-help skills that your child has or needs assistance with? Ex: _____

What is your #1 goal for self-care that you would like to see your child doing independently within the Next year?

Are there any traditions or customs that we should be mindful/aware of?

Functional Behavioral Assessment Questionnaire

Child's Name: _____

Goals of Intervention: What goals would you like to achieve for your child and family?

What would you like your child/family to be able to do that is currently not possible or extremely difficult (e.g., having dinner as a family, playing with friends, exercising, completing chores)?

_____
_____
_____

Where would you like your child/family to be able to go that you now avoid (e.g., dining at a restaurant, attending religious services, extracurricular or sports events)?

_____
_____

What changes would you like to see as your child's behavior improves and he/she gains additional skills (e.g., making own choices, less supervision required, health or emotional changes)?

_____
_____

Child's Strengths: What are your child's greatest strengths (e.g., skills, interests)?

_____
_____
_____

Potential Reinforcers: What does your child like (i.e., if presented with a variety of options or given free time, what would your child choose)?

Attention (e.g., conversation, eye contact, touch)_____
Tangibles (e.g., activities, toys) _____
Sensations (e.g., smells, sights) _____

Predictability of Events

Is your child's daily schedule consistent (i.e., Do meals, bedtimes, and other daily events occur at the same time and in the same order)? Yes No

Do you feel that your child generally knows what is going to happen (e.g., where the child will be going, when, and with whom)? Yes No

Opportunities for Choice: Please describe the different types of choices your child has the opportunity to make on a regular basis (e.g., what to wear, with whom to play, what activities to do):

_____

_____

Possible Triggers: What impact would you expect the following situations to have on your child's behaviors of concern?

Situation	More Likely	No Impact	Less Likely	Notes
Asked to do a difficult task				
Told no or to stop activity				
Attention is withdrawn				
Change in routine/schedule				
Loud or chaotic situations				
Required to wait/delayed				
Other situations that are particularly difficult:				

Beyond the Spectrum

INITIAL & ANNUAL CONSENT TO PARTICIPATION

Client: _____ DOB: _____

Parent/Guardian: _____

The following material is provided to clarify the features of our program and ensure informed consent for participation of the above named individual (referred to as the "individual throughout this document) in the assessment and subsequent intervention. Please review this material and initial each section and then provide your signature at the end of the document.

Overview of Services: Amy Labrie is a BCBA serving individuals with disabilities and behavioral challenges in the state of Florida. Both myself, and my behavior assistants are independent contractors. Our services are designed to meet the unique needs of the individuals we serve and are subject to availability of qualified staff.

In my treatment, I provide principles of applied behavior analysis and person and family-centered practices. The overarching goal is to produce lasting changes in the quality of life of the people i serve. It involves conducting a comprehensive assessment to develop interventions in collaboration with family members, educators and direct services providers and others caring for the individual. The following flowchart provides an overview of the process.

Assessment - Identify goals and individual's behaviors of concern, Complete record reviews and interviews with caregiver,s Conduct observations across activities and settings
Plan Design - Identify patterns surrounding behavior (ABC), Develop interventions to prevent problems, teach skills, and respond effectively - Create a comprehensive written behavior support plan
Intervention -Provide training for caregivers using modeling and feedback, Coach implementation, gradually fading assistance
Evaluation - Gather data on child behavior, skill development, and life changes, Monitor and report on progress, adjusting strategies as needed, Graduate from services when goals are achieved
S

Settings/Participants: Intervention is most effective when developed based on patterns across all settings in which there are concerns and involving support providers in those settings. Please complete the following table on the locations in which you would like the assessment and subsequent intervention to occur. Please provide the address and names of participants in each setting and circle yes or no to indicate your consent to access these sites and individuals.

Location	Address	Participants	Consent
School			
Clinic			
Other			

I will do my best to schedule services around the needs and preferences of my clients. Our Hours of availability are Monday-Friday 8:30-4:30. What days and times would work best for you?

Monday	From:	To:
Tuesday	From:	To:
Wednesday	From:	To:
Thursday	From:	To:

Friday	From:	To:

Maintaining the safety of my clients and contractors is critical to service delivery. For this reason, my assistants and I will not enter or work in environments that pose significant risks; these include settings with environmental hazards (e.g., weapons, dangerous chemicals, broken glass, unsafe structures, etc.) or in which the residents or participants are using narcotics or engaging in violent or threatening behavior. Contractors may utilize an environmental safety checklist to identify potential risks prior to beginning services.

Crisis Management - Given the nature of the challenges individuals who participate in our services face, it is not uncommon for an individual to engage in behavior that puts him/her or others at risk. If this occurs, the crisis will be managed using the least intrusive and safest strategies to curtail the behavior. I will make every effort to avoid provoking this type of behavior unnecessarily and to respond quickly to address problems as soon as they arise (e.g., through prompting communication, presenting choices or assistance, clarifying expectations, or using redirection). If the individual becomes aggressive or self-injurious, these behaviors may be managed by blocking strikes, removing the person or others, changing the surroundings, or restraining the individual briefly using an approved crisis management procedure and in accordance with chapter 65G-8, section 393.13 (4)(h) 2 of the Florida Statutes. If the caregivers and staff are unable to manage the behavior safely, they will call 911 and/or seek assistance from another professional. If medical attention is required, the parent/guardian/caregiver will need to provide transportation. Specific crisis management procedures will be incorporated into the individual's behavior support plan.

Rights of Our Clients Individuals with disabilities (and behavioral challenges) have the same rights as everyone else. I embrace the Bill of Rights for the Developmentally Disabled and does everything in its power to uphold these rights. These rights specify that individuals and their families must be treated with dignity and that behavioral procedures must be explained in user-friendly terms. This Bill of Rights is attached and will be reviewed with parents/guardians/individual during intake and annually, obtaining signatures to indicate acknowledgement and understanding.

Individuals also have the right to be free from abuse. If someone suspects that an individual is being abused or neglected, this should be reported to the abuse hotline at the following number: 1-800-962-2873

Infectious Disease Reporting I adhere to state and federal guidelines outlined by the department of health in reporting confirmed and suspected cases of infectious disease(s). If any staff - or a caregiver - suspects or confirms infectious disease in an individual, they are obligated to report it to their local or regional health department at the following number: 1-800-705-8868

Risks and Benefits Participating in any treatment has numerous benefits, but also certain inherent risks. For example, individuals receiving services may experience disruptions in daily life (e.g., due to professionals entering the setting or suggesting changes in routines), stress associated with identifying problematic patterns or learning to respond differently to the individual's behavior, or frustration at delays in progress or the necessity to modify approaches periodically. These are, of course, in addition to risks to privacy and confidentiality that occur when sharing information. I will make every effort to minimize these risks and make services optimally beneficial and enjoyable.

Acknowledgement and Consent I certify that I have authority to legally consent to assessment, release of information, and all legal issues involving my child. Upon request, I will provide my analyst with proper documentation of guardianship. If my status as legal guardian should change, I will immediately inform my analyst and provide the name, address, and phone number of the person(s) who have assumed that role.

Thereby I acknowledge that I have received information on participation expectations and policies regarding records release, confidentiality, payment, appointment cancellation, discharge, and grievance procedures and have had the opportunity to ask questions and get clarification regarding these requirements and processes. I have received a summary of the HIPAA Privacy and Security Standards, Recipient Choice and Rights, and abuse hotline number. This consent will be updated annually.

I acknowledge that accessing services through a private analyst is a choice and that I have the right to change companies or request a change in my behavior analyst, behavior assistant, mental health professional, and/or intern at any point. I provide my consent for my child to participate in an assessment through Beyond the Spectrum in the settings have indicated. I agree to participate fully in this process, meeting under mutually agreed upon time and place. My consent expires one year after termination of services/from the date below. Thereby agree to these terms.

PARENT/GUARDIAN:
DATE:

PARENT/GUARDIAN:
DATE:__

INDIVIDUAL:
DATE:

BEHAVIOR ANALYST SIGNATURE:
DATE:

WITNESS:
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

Client Name: _____

For clients who do not have insurance:

- Clients who do not have any insurance coverage are expected to pay bi-weekly basis. An invoice will be sent out with the expectation that it will be paid in full within 2 weeks.
- Clients who are currently covered by insurance: the client is responsible to provide valid insurance information and should provide their insurance card in the event coverage changes.
- It is important for you to make sure we are in-network and we are currently a provider with your insurance company.
- If we are currently a provider with your insurance company, the necessary forms will be completed and submitted, and secondary insurances will be billed when applicable.

If you are covered by an HMO or Managed Care Plan

- The client is responsible to pay any co-payment or any portion of the charges as specified by the plan mentioned above.
- The client is responsible to ensure that any required referrals for treatment are provided to the practice at the time of the therapy. Therapy may be rescheduled, or the patient may be financially responsible due to the lack of the referral
- We reserve the right to charge for the completion of forms and letters. For example, insurance or different programs and the copying or records
- Any outstanding balance either not paid in full or under a payment plan agreement can be transferred to an outside collection agency.

In Network Plans

- The client is responsible to pay any co-payment or any portion or the charges as specified by the plan at the time of the visit
- Any medical services not covered by an individual's insurance plan are the client's responsibility and payment in full is due at the time of the visit. Specific coverage issues should be addressed by the insurance company's member services department.

Notification of Benefits

- 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.

Signed this ___ day of _____, 20__

_____ _____

Printed name of responsible party Signature of responsible party

_____ _____

Printed name of witness Signature of witness

AUTHORIZATION TO DISCUSS INFORMATION

I hereby authorize you to use or disclose specific information described below, only for the purposes and parties described below

Description of the specific information to be discussed:

- ☐ Attendance
- ☐ Medication
- ☐ Billing/payments
- ☐ Behavior Intervention Plan
- ☐ Field trips
- ☐ Incident/Injury Reports
- ☐ Group/Other Therapies (OT, Speech)
- ☐ All
- ☐ Academic goals/status
- ☐ Funding
- ☐ Behaviors
- ☐ Other (specify): _____

Student/Client Name: _____
Date of Birth: _____
Information to be given to: _____

Name: _____
Relationship: _____
Address: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
Phone: _____
Email: _____

This authorization shall remain in effect from the date signed below until (please check one):

- ☐ _____(specify expiration date)
- ☐ End of school year
- ☐ End of calendar year
- ☐ No Expiration date

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing and providing to your office
- This authorization is giving Beyond the Spectrum and its employees, the right to discuss my student's information with one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPPA
- I may refuse to sign this authorization and you will not disclose any confidential information to individuals who do not have legal guardianship

Signed this ____ day of _____, 20__

_____ _____

Phone: (941) 907-3443 email: abaclinic@beyondthespectrum.org

Printed name of parent/guardian	Signature of parent/guardian
Printed name of witness	Signature of witness

Phone: (941) 907-3443 email: abaclinic@beyondthespectrum.org

Beyond the Spectrum

Individual/Caregiver and Provider Contract

Individual: _____ DOB: _____

Caregiver: _____

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.
4. I understand that in order for this intervention to be successful, I may be required to put forth a good deal of effort.

Expectations for participation

To achieve the best possible outcomes for the individuals I serve, it is essential to fully engage and empower families and other caretakers to carry interventions over into homes, schools, and communities. Instead of simply providing direct services, much of ABA works in collaboration with others supporting the individual. As a partner in this process, you are agreeing to work closely with the BCBA and assume mutual responsibility for the individual's success. That means communicating with the BCBA regarding goals, needs, and challenges. It also means taking an active role in the process. Specifically, you agree to:

A. Communicate with members of the individual's support team (Ex. Therapists, teachers)
B. Gather information to track the individual's behavior and circumstances surrounding it such as taking data collection
C. Help us to design a behavior support plan that is feasible for you and your family
D. Actively participate in the coaching sessions to practice the support plan strategies
E. Make your best effort to implement the strategies on an ongoing basis, providing the BCBA on the plan's effectiveness.

Parent/Guardian: _____ Date: _____

Confidentiality Act/ Abuse Reporting Protocol

Individual: _____

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.
4.

Parent/Guardian: _____ Date: _____

Grievance/ Discharge Procedure

Grievance: If you are not satisfied with the services you receive by the staff assigned to you, please first call the behavior analyst assigned to your case. 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 and transition case.
2. Any child whom 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.

If an individual is discharged, it is of best practice that the analyst provides 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 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.

Cancellation Policy:

If you reach the staff person before he/she has left to come to the clinic, it is considered a cancellation. If there are 3 cancellations in a row, your case will be closed unless otherwise determined by the behavior analyst. If you cancel 3 times, with periodic attendance in between each cancellation, your assigned staff will discuss with you possible solutions to the problem of irregular attendance. Cancellations without 12 hour notice will be charge a $50 appointment fee.

No Show Policy:

If you do not call to cancel before the staff person has left to go to the clinic, it is considered a no show. After the first no show, the staff person will call you to reschedule the appointment. After the second no show, you will be sent a letter explaining that you must notify the analyst on the case in writing if you desire to continue services. After the third no show, your case will be closed and services terminated.

Consent for Service Delivery:

I have the right to choose any analyst for my services. I understand that this is completely my choice and that I have the right to change companies or request a change of BCBA/RBT at any time. I agree that my analyst will meet with me under mutually agreed upon time and place.

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

Parent/Guardian: _____ Date: _____

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 Amy Labrie (hereafter Analyst) 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. _____

TREATMENT CONSENT FORM FOR ABA SERVICES

Individual: _____ DOB: _____

I consent for behavioral treatment to be provided for the above-named individual by Amy Labrie, BCBA. 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: _____

Beyond the Spectrum

AUTHORIZED PICK-UP AND CLIENT RELEASE FOR _____ (CHILD'S NAME)

Beyond the Spectrum uses the following criteria to assure each child is picked up or removed from the preschool by authorized persons only:

1) No child will be released to any person whose name does not appear on this Authorization Pick-Up List or has been approved and added by using the Authorization Addition Form.

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. This new pick up person will not be added to the permanent list unless you specify.

6) All authorized pick-up persons MUST complete the Authorization Affidavit, in order to enter the facility

For your child's protection, THEY WILL NOT be released to an unauthorized person. Approved picture identification (driver's license) will be required. A list of these persons will be placed in each classroom.

List below those who have permission to pick up your child:

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

Beyond the Spectrum (BTS) defines a legal parents or legal guardian to be person(s) who enrolled the child and whose signature is found on the enrollment 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 that he/she has been awarded temporary or permanent custody of the child in question. We will not hesitate to call 911 immediately if any disruptions or disputes develop on school property.

The safety or the minor child in our custody will always take top priority in any situation. This also applied to those allowed to pick up the child from BTS. ONLY official court documents, whose authenticity has been verified, will supersede any other documents received or placed on file.

I hereby authorize all above listed names as active and approved people to pick up my child from the Beyond the Spectrum facility.

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

ACTIVITY PARTICIPATION AND TRANSPORTATION RELEASE

I, the undersigned, hereby request transportation coordinated and conducted by Beyond the Spectrum to be provided for the child named herein and have full legal authority to do so. I agree to allowing Beyond the Spectrum employee or other designated representative to transport my child in their own personal vehicle or other designated vehicle at their sole discretion. I understand that the driver will carry their own personal automobile insurance, will be CPR/First Aid certified, and will have a valid state driver's license. I understand that if my child needs specific safety items such as a car seat, booster seat, seatbelt cover or additional items, it is my responsibility as the parent/guardian to provide such items.

I fully understand that traveling by vehicle involves certain risks and dangers, including injury and death, caused by the actions of others. There may be other risks and social and economic losses either known or unknown to be or not readily foreseeable at this time. This Waiver and Release of Liability made by and between me on behalf of myself/or child and Beyond the Spectrum, I HEREBY FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND RESPONSIBILITY FOR LOSSES, COSTS AND DAMAGES that may be caused to me or my child, or that I/we may incur as a result of my or my child's participation in said transportation.

I hereby release, discharge, indemnify, hold harmless and covenant not to sue Beyond the Spectrum, its administrators, directors, agency, partners, contractors, volunteers, affiliates, and employees ("Releasees") from any and all liability, claims, demands, losses or damages on my account caused or alleged to be cause in whole or in part by the negligence of the Releasees or otherwise, and I further agree that it, despite this release and waiver of liability, assumption of risk, and indemnity, I, or anyone on my behalf, makes a claim(s) against any of the Releasees, I will fully indemnify and hold harmless each of the Releasees from any and all litigation expense, including all attorney fees, loss, liability, damage, or cost which may incur as a result of such claim.

Signed this ____ day of _____, 20__

_____
Child's Name

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

CONSENT TO PARTICIPATE IN ASSESSMENT AND RECORDS RELEASE

Client: _____ D.O.B.: _____

Address: _____

_____

Phone: _____ Alternative Phone: _____

Parent/Legal Guardian Name: _____

I consent for the above-named individual to participate in assessment through the ABA Clinic at Beyond the Spectrum. I consent to have the assessment with the above-named individual conducted at the following locations

- ☐ Home _____
- ☐ School _____
- ☐ Other _____

Parent/Legal Guardian: _____ Date: _____

I understand and consent to have the individuals responsible for care in the above-named locations involved in the assessment of the above-named individual. In order to coordinate the assessment with these individuals, I authorize the release of the following confidential records to the individuals responsible for care in the above-named locations:

- ☐ Insurance Information
- ☐ IFSP or IEP
- ☐ Medical records
- ☐ Semi Annual and Annual Reports
- ☐ Behavior program or Treatment Plans
- ☐ Other _____
- ☐ Psychosocial History
- ☐ Progress Notes

I understand records may contain psychiatric and or drug and alcohol information. I understand that these records may also contain references to blood born pathogens (e.g. HIV, AIDS).

I understand that my records are protected by data practice laws and cannot be release without mt consent unless otherwise allowed by law. Only the information and records indicated above will be released or obtained and consent does not authorize the recipient of the information/records to re-disclose the information/records to any other person or facility unless authorized by law.

I understand that the information will only be used for the therapy of the above-named client and I may withdraw or modify this consent at any time but the modification/revocation will not affect any previously released information.

Information may be shared in person or by mail. I give permission to share information using the following methods:

- ☐ Phone
- ☐ All
- ☐ Other _____
- ☐ Email
- ☐ Verbal
- ☐ Fax
- ☐ Written

I understand that the ABA Clinic at Beyond the Spectrum will maintain individual's records in a safe and locked location and maintain protected electronic records of individual data.

THIS CONSENT AUTOMATICALLY EXPIRES 1 YEAR AFTER TERMINATION OF SERVICES

Parent/Guardian: _____ Date: _____

Phone: (941) 907-3443 Fax: (941) 527-0526 email: amy.labrie@beyondthespectrum.org

BEYOND THE SPECTRUM
7333 INTERNATIONAL PLACE, SARASOTA, FL 34240 PHONE (941) 907-3443

MEDICATION/TREATMENT AUTHORIZATION

Instructions: Read instructions on page two prior to completing the form.

Student Name _____ Sex _____ DOB _____ Grade _____

School _____ Student Class _____ Fax No. _____

The following section is to be completed by the parent or legal guardian.

I hereby grant permission to the principal or his/her designee of **BEYOND THE SPECTRUM** to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S.1006.062). **It is my responsibility to notify the school if, and when these orders change.** I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication and/or treatment where the person administering such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Parent/Guardian Name _____ Relationship _____

Emergency Phone___ Home Phone _____ _____

_____
Work Address

List student allergies _____

Parent/Guardian Signature _____ Date _____

The following section is to be completed by the prescribing physician. A separate form must be completed for each medication or treatment prescribed. The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, which is necessary to be given in school. I am aware that trained nonmedical staff may administer this physician prescribed service.

This order is to be effective for the school year: 20____ - 20____ or earlier stop date _____.

Diagnosis (for this medication/treatment)
Treatment
Name of Medication Brand Generic Strength (i.e. mg/tab)
Instructions to give Amount (i.e. No. of tablets or teaspoons) _____ Time(s) _____
Frequency (i.e: every 6 hrs PRN) Duration (i.e: 10 days)
Route ☐ Oral ☐ Topical ☐ Subcutaneous ☐ I.M. ☐ Inhaled ☐ Other (describe)
Time medication is given at home (if applicable)
Possible side effects
Medication expiration date to follow manufacturer's expiration date? ☐ Yes ☐ No
Is student authorized to carry and use asthma inhalation medication or Epinephrine Auto-Injector? ☐ Yes ☐ No
Has student been instructed in the use of asthma inhaler or Epinephrine Auto-Injector? ☐ Yes ☐ No
Is student authorized to carry and self-administer pancreatic enzymes? ☐ Yes ☐ No
Has student been instructed in the use of pancreatic enzymes? ☐ Yes ☐ No
Other Information
Physician Name _____
Office Address _____ Phone _____ Fax _____
Physician Signature _____ Date _____
Medication order reviewed by school RN/LPN _____ Date _____
Medication stopped by Parent/Guardian Signature _____ Date _____

MEDICATION/TREATMENT AUTHORIZATION

Instructions: For medical/treatment administration during school hours, read the below requirements.

If your child needs to have medication(s)/treatment(s) given during the school day, state regulations and schoo' board policy require that you and your doctor provide written permission for administration of both prescribed and over-the-counter medication(s) or treatment(s).

Medication refers only to those products which have been approved by the "Food and Drug Administration" (FDA) for use as a drug.

- **Prescribed medications** must arrive in a container with the original, unaltered prescription label attached. **The label must display all legal information required for a pharmacist to dispense a prescription medication such as valid issue and expiration dates, the patient's name, the medication name and dosage instructions, and the doctor's name. The label information must match the physician's order.**

- **Over-the-counter medications** must arrive in the original, unopened store-issued container. Take the time to label the container with your child's full name and birth date, the date you brought the medication to school and the **dosage prescribed by the doctor.**

- The Medication/Treatment Authorization Form on the reverse side of this document must be completed entirely and accompany any medication (either prescribed or over-the-counter) to be given to your child in school. **Both a parent/legal guardian and the prescribing doctor must sign the form.** Staff will not be able to administer medications to your child without this **written consent**.

- The parent, legal guardian, or an authorized adult must hand carry medications to the school health room. The medication brought into the school health room must match the prescribed medication amount. For example, if the prescribed amount is ½ tablet, then it is the responsibility of the pharmacy/parent to cut the tablets. The health room aide upon receipt will verify the quantity of each medication. **Albuterol and Epinephrine Auto-Injectors must be delivered in the original box with the pharmacy label. Do not send medications to school with your child.**

- **The ADMIN at your child's school may need to call the doctor's office for medication/treatment clarification.**

The parent or legal guardian will need to pick up the medication at the end of the school year or if the medication is discontinued or changed during the school year. **If the medication is not picked up, it will be discarded.**

BEYOND THE SPECTRUM OF SARASOTA COUNTY

MEDICATION AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION
MIDDLE SCHOOL AND HIGH SCHOOL STUDENTS ONLY

Instructions: Return this completed form to the Front Desk.

Student Name_____ DOB_____ Sex_____
School: BEYOND THE SPECTRUM

List Child's Allergies _____

I grant permission to the principal or his/her designee to assist in the administration of over-the-counter medication to my child while in school and while participating in field trips. I will supply the named medication in an unopened, original store issued container. I understand that it is my responsibility to hand carry medication to the school health room. **(Do not send medication to school with your child.)** I understand that this agreement is valid until I terminate permission or until the end of the current school year. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Mark only one box below. **(No other medications have been approved.)**

☐ Tylenol or Acetaminophen	(One) 325 mg (regular strength) tablet or 325 mg chewable equivalent every 4 hours as needed (No liquid)

Children must be 12 years of age or older for the medications listed below.

☐ Tylenol or Acetaminophen	(Two) 325 mg (regular strength) tablets or 650 mg chewable equivalent every 4 hours as needed (No liquid)
☐ Tylenol or Acetaminophen	(One) 500 mg (extra-strength) tablet every 4 hours as needed
☐ Advil/Motrin or Ibuprofen	(One) 200 mg (regular strength) tablet or 200 mg chewable equivalent every 6 hours as needed (No liquid)
☐ Advil/Motrin or Ibuprofen	(Two) 200 mg (regular strength) tablets or 400 mg chewable equivalent every 6 hours as needed (No liquid)

Parent/Guardian Name _____

Emergency Phone _____ Home Phone _____

Work Phone _____ Cell Phone _____

Address _____
Street City State Zip

Parent/Guardian Signature _____ Date _____

_____ _____

Medication Order Reviewed By School ADMIN Name (Print) and Signature Date

RET: Master, 7Y GW, GS7 158 045-09-HEA Dupl., OSA Rev. 4-5-2019

BEYOND THE SPECTRUM SARASOTA COUNTY

MEDICATION AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS

Instructions: Return this completed form to the Front Desk.

Student Name _____

Date of Birth _____ Sex _____ School Year 20 _____ - 20 _____ Grade _____

School Name _____

List child's allergies

_____

I grant permission to the principal or his/her designee to assist in the administration of over-the-counter medication to my child while in school. I will supply the named medication in an unopened, original store issued container. I understand that it is my responsibility to hand carry medication to the school health room. **(Do not send medication to school with your child.)** I understand that this agreement is valid until I terminate permission or until the end of the current school year. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

No other medications have been approved.

☐ Desitin	For use on diaper area: (circle) Rapid relief cream, maximum strength original paste, or multi-purpose ointment
☐ Balmex	For use on diaper area: (circle) Multi-purpose ointment, or diaper rash cream
☐ A and D	For use on diaper area: (circle) Original ointment, or zinc oxide cream
☐ Vaseline	Apply to unbroken skin areas directed by parent
☐ Insect Spray	Apply per package directions

Parent/Guardian Name (Print) _____

Emergency Phone _____ Home Phone _____

Work Phone _____ Cell Phone _____

Address _____
Street City State Zip

Parent/Guardian Signature _____ Date _____

_____

_____ _____
Medication Order Reviewed By ADMIN Name (Print) and Signature Date

SEIZURE PLAN

Client Name: _____ DOB: _____
Address: _____ Phone: _____

Emergency Contacts

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

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

Other seizure treatments
Device type: _____ Model: _____ Date implanted: _____
Serial #: _____

Dietary Therapy: _____
Special Instructions: _____ Other Therapy: _____

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

"As Needed" Treatments (VNS magnet, medicines, etc.)

Name	Amount to Administer	When to Administer	How to Administer

Health Care Contact

Epilepsy Doctor:	_____	Phone:	_____
Nurse/Other Health Care Provider:	_____	Phone:	_____

Preferred Hospital:		**Phone:**	
Primary Care:		**Phone:**	
Pharmacy:		**Phone:**	

Special Instructions

Parent/Guardian Signature	**Date**	**BTS Staff Signature**	**Date**

Beyond the Spectrum

ABA Clinic Parent Handbook

7333 International Place
Sarasota, FL 34240
Office Number: 941-907-3443
Website: www.beyondthespectrum.org

BCBA: Amy Labrie
Amy.Labrie@beyondthespectrum.org

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 8:30 am to 4:30 pm. Service times are individualized per client and the therapeutic services recommended.

The Clinic at BTS Observed Holidays 2021

Jan 1	New Year's Day	May 25	Memorial Day	Nov 25	Thanksgiving	Dec 25	Christmas
Jan 20	MLK Day	Jul 5	Day after Independence	Nov 26	Black Friday	Sept 6	Labor Day
Feb 17	President's Day	Nov 11	Veteran's Day	Dec 24	Christmas Eve		

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

Clinic at BTS

2021 Calendar

January 01

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

February 02

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28						

March 03

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April 04

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May 05

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June 06

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July 07

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August 08

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September 09

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October 10

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24	25	26	27	28	29	30
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November 11

Sun	Mon	Tue	Wed	Thu	Fri	Sat
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21	22	23	24	25	26	27
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December 12

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

The Clinic at BTS Observed Holidays 2021

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Feb 15	President's Day	Sept 6	Labor Day	Dec 24	Christmas Eve		
		Nov 11	Veteran's Day				

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 a minimum of 1x/week for 30 min or 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 the lobby each morning and meet parents in the lobby 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.

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 the 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 ziptop 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 with be 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 program director 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. Cancellations with less than 12 hour notice are charged $50 per appointment.

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 school 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.

Late Arrivals

If there is an unexpected situation and you are going to be late dropping off your child, please call 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. 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 the behavior assistant is still available to provide services, 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.

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 **$50 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
- Behavioral changes
- Hand Foot Mouth
- Measles/ Mumps
- Diarrhea
- Strep Throat
- Chicken Pox
- Lice
- Pink Eye
- 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. Medical 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.

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. There are a few observation windows available to observe without your child seeing you. 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.

THIS SHOULD REMAIN WITH THE INDIVIDUAL OR CAREGIVERS

HIPAA Privacy and Security Standards

Policies and Practices to Protect the Privacy of Your Health Information (HIPPA Policy)

THIS NOTICE DESCRIBES HOW ALL MEDICAL INFORMATION ABOUT THE CLIENTS WE SERVE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. **Uses and disclosures for Treatment, Payment, and Health Care Operations**

The behavior analyst may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent as stated on the online referral form.

To help clarify these terms, here are some definitions:

- **PHI**–refers to information in your health record that could identify you.
- **Treatment**-is when a health care professional provides, coordinates, or manages your health care and other services related to your health care.
- **Payment**–is when I obtain information about your healthcare benefits and eligibility and/or attempts to obtain and/or obtains reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- **Health Care Operations**–is when I disclose your PHI to your health care service plan (for example your health insurer), or to other health care providers contracting with your plan, for administration of the plan, such as case management and care coordination.
- **Use**–applies to activities within my office such as sharing, applying, utilizing, examining, and analyzing information that identifies you.
- **Disclosure**–applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.
- **Authorization**– means written permission for specific uses or disclosure.

II. **Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when an appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment and payment operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your therapy progress notes. Therapy progress notes are notes your therapist has made about your conversation, actions, observations, etc, during an individual, group, joint or family treatment session, which are kept separate from the rest of your medical records. These notes are given a greater degree of protection of PHI. You may revoke all such authorizations of PHI at any time; however, the revocation or modification is not effective until received by me in writing.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If any Team Member knows or suspects that a child has or is being abused, abandoned, neglected, or neglected, the law requires that they report such knowledge or suspicion to the proper authorities according to the county and state you reside in.
- **Adult and Domestic Abuse:** If any Team Member knows or suspects, that a vulnerable adult(disabled or elderly) has been or is being abused, neglected, or exploited, they are required by law to immediately report such knowledge or suspicion to the local number located in the Rights of Our Clients section.

- **Health Oversight:** If a complaint is filed and later is open for investigation; a subpoena for confidential health information from certain parties may requested and therefore shared.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information regarding your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I must communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

IV. Patients' Rights and Therapist's Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- **Right to Received Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and alternative locations. For example, you may not want a family member to know you are in treatment. Upon request, I will send your bills to another address.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI of my treatment and billing records used to make decisions about you for as long as the PHI is maintained in the record. Upon your request, I will discuss the details of the request process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record; however I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive this notice electronically.
- I am required by law to maintain the privacy of PHI and to provide you with a notice of my privacy practices with respect to PHI.
- I reserves the right to change the privacy policies and practices described in these notices. Unless you are notified of such changes, however, we are required to abide by the terms currently in effect.
- If I revise privacy policies and practices, I will make my best effort to contact you with this information in person, by telephone, by email, or by mail. For this reason, it is important that you notify me immediately of any address, telephone, or email changes.

V. Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me directly. You have specific rights under the privacy rule. I will not retaliate against you for exercising your right to file a complaint.

Recipient Choice and Rights

RIGHTS OF ALL PERSONS WITH DEVELOPMENTAL DISABILITIES.--The rights described in this subsection shall apply to all persons with developmental disabilities, whether or not such persons are individuals of the agency.

(a) Persons with developmental disabilities shall have a right to dignity, privacy, and humane care, including the right to be free from sexual abuse in residential facilities.

(b) Persons with developmental disabilities shall have the right to religious freedom and practice. Nothing shall restrict or infringe on a person's right to religious preference and practice.

(c) Persons with developmental disabilities shall receive services, within available sources, which protect the personal liberty of the individual and which are provided in the least restrictive conditions necessary to achieve the purpose of treatment.

(d) Persons with developmental disabilities shall have a right to participate in an appropriate program of quality education and training services, within available resources, regardless of chronological age or degree of disability. Such persons may be provided with instruction in sex education, marriage, and family planning.

(e) Persons with developmental disabilities shall have a right to social interaction and to participate in community activities.

(f) Persons with developmental disabilities shall have a right to physical exercise and recreational opportunities.

(g) Persons with developmental disabilities shall have a right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse, or neglect.

(h) Persons with developmental disabilities shall have a right to consent to or refuse treatment, subject to the provisions of s. 393.12(2)(a) or chapter 744.

(i) No otherwise qualified person shall, by reason of having a developmental disability, be excluded from participation in, or be denied the benefits of, or be subject to discrimination under, any program or activity which receives public funds, and all prohibitions set forth under any other statute shall be actionable under this statute.

(j) No otherwise qualified person shall, by reason of having a developmental disability, be denied the right to vote in public elections.