Marigold
ABA Therapy Center

REFERRAL FORM ORDER

DATE: _____

NAME OF REFERRING PHYSICIAN:_____

ADDRESS:_____

_____

PHONE: _____

DIAGNOSIS

☐ F84.0 - Autism Spectrum Disorder (ASD)
☐ F84.9 -Pervasive Developmental Disorder- NOT Otherwise Specified (PDD-NOS)
☐Other (please write DX Code): _____

REQUESTED THERAPY

☐ Assessment for Applied Behavior Analysis Therapy (ABA)
☐ Applied Behavior Analysis Therapy (ABA)
☐ Social Skills Therapy
☐ Other: _____

PATEINT INFORMATION

Name _____

Address: _____

_____

D.O.B: _____ **Phone Number** :_____

Please attach the following to Marigold, marigoldlearningacademy@gmail.com or fax to number below to initiate services.

- This referral form
- Healthcare insurance card (front & back copy)
- Evaluation/Assessment report for diagnoses F84.0

_____ _____

Physician Signature Date

ADMISSION INFORMATION

Operation Name	Director's Name
Marigold Learning Academy	Karri Wilson

Child's Full Name	Child's Date of Birth	Child's Home Telephone No.

Child's Home Address		
Date of Admission	Date of Withdrawal	

Parent's or Guardian's Name	Address (if different from child's address)

List telephone numbers below where parents/guardian may be reached while child will be in care:

Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No

Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached:	Relationship

I hereby authorize the Marigold Learning Academy to allow my child to leave the school **ONLY** with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

1.	2.	3.

CHECK ALL THAT APPLY:

1. ☐ TRANSPORTATION: I hereby ☐ give ☐ do not give – consent for my child to be transported and supervised by the school employees:

Walk home ☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. ☐ FIELD TRIPS: I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:

Parent's Comments:

3. ☐ WATER ACTIVITIES: I hereby ☐ give ☐ do not give – my consent for my child to participate in Water Activities:

☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ water table play

4. ☐ RECEIPT OF WRITTEN OPERATIONAL POLICIES:

I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:

☐ **None** ☐ **Breakfast** ☐ **AM Snack** ☐ **Lunch** ☐ **PM Snack** ☐ **Supper** ☐ **Evening Snack**

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Ph.#:

Name of Emergency Medical Care Facility:	Address:	Ph.#:

I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____
Signature - Parent or Legal Guardian

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which the Director should be aware of:

_____

_____

IMMUNIZATION RECORD:

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

_____ _____

Signature – Parent or Legal Guardian Date

Authorization for Release of Information and Records

Note: Use a new form for each provider.

I/We hereby give **permission and consent** to Marigold Learning Academy ABA Therapy Center to release confidential information in my' child's clinical record (e.g., behavioral assessments, behavioral data, etc.) to the following practitioner:

Name: _____

Title: _____

Company/School/Practice: _____

Address: _____

_____

Phone: (_____) _____- _____

Client's Name: _____Date of Birth: _____/_____/_____

Parent/Guardian #1: _____
(Print Name)

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

Parent/Guardian #2: _____
(Print Name)

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

Marigold
Learning Academy
& ABA Therapy Center

Client Illness Policy

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

Sickness includes, but not limited to the following:

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

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

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

If your child arrives at the clinic and is sick, our staff will advise you to take your child home. If for home programming, a therapist arrives at the home and the child is sick, the therapist will not be able to work with your child and you will be charged for the session, which will not be reimbursable through insurance, for failure to report your child as sick and adhere to this policy.
I/We understand MLA's policy on client illness and agree to adhere to this policy.

Parent/Guardian #1: _____
(Print Name)

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

Parent/Guardian #2: _____
(Print Name)

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

Marigold
Learning Academy
& ABA Therapy Center

Fee Agreement and Payment Policy Template

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

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

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

IN-NETWORK: MLA is in-network with the following insurance companies: Aetna, Tri-Care, Cigna, Magellan, Scott and White, BCBS Anthem. We will assist in filing all of your claims for applied behavior analysis services. I/We agree to pay MLA for all co-pays and deductibles when services are rendered.

Payments for services are billed per hour.

LATE FEES AND COLLECTIONS: If payment is not received when services are rendered, a 5% service charge will be added for each week the balance is past due. If payment is not received within 60 days, the bill may be sent to a collection agency. Additionally, I/we understand and agree to pay any and all collection costs and/or attorney fees if any delinquent balance is placed with an agency or attorney for collection, suit, or legal action. I/We also acknowledge that confidentiality is waived in matters involving collections and the sharing of information sufficient to pursue recovery of debts owed. Also, if your check is returned by the bank you will be billed a $45.00 returned check fee and alternative arrangements will have to be made to satisfy your obligation. For your convenience, we accept MasterCard, Visa, American Express, Discover, cash, and checks.

Rockwall: 401 W Washington St., Rockwall TX, 75087 *Greenville: 2300 Joe Ramsey Blvd. Ste B, Greenville TX, 75041*
Phone: 972-722-3892 *Fax: 214 -602-2729*

RATES FOR SERVICES:
$460.00 ABA Therapy Assessment and Treatment Planning
$90-$120 BCBA Service Provider, $50 - $70. BCABA, RBT Service Provider
Insert fee schedule here for out-of-network services and travel charges, if applicable.

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

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

If you have any questions regarding our Fee Agreement and Payment Policy, please do not hesitate to discuss it with us by contacting MLA. If you have any questions or concerns regarding billing and insurance, please contact our billing specialist, Tish Munoz, at (972)722-3892.

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

Parent/Guardian #1: _____
(Print Name)

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

Parent/Guardian #2: _____
(Print Name)

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

Rockwall: 401 W Washington St., Rockwall TX, 75087 *Greenville: 2300 Joe Ramsey Blvd. Ste B, Greenville TX, 75041*
Phone: 972-722-3892 *Fax: 214 -602-2729*

In-Take Questionnaire Template
CONFIDENTIAL

Please complete this intake questionnaire regarding your child. Feel free to add any additional information or attach additional reports that you think may helpful for us in getting to know your child. MLA views all of the information that you provide us with as strictly confidential. This information is helpful for us in developing an initial understanding of your child's needs and provides critical information for us to discuss with your insurance company to get authorization for services.

Please type or write response

Today's Date: _____/_____/_____

GENERAL INFORMATION

Name of Person Completing this Form:

Relationship to Child/Adolescent:

Legal Name of Child/Adolescent:

Child/Adolescent's Date of Birth: _____/_____/_____ Age: _____

How did you hear of our ABA agency?

PARENT/GUARDIAN CONTACT INFORMATION

Home Telephone: (_____)-_____-_____

Parent/Guardian 1 Employer: _____ Cell Phone: (_____)-_____-_____

Parent/Guardian 1 Cell Phone: (_____)-_____-_____ Email: _____

Parent/Guardian 2 Employer: _____ Cell Phone (_____)-_____-_____

Parent Guardian 2 Cell Phone: (_____)-_____-_____ Email: _____

MEDICAL INFORMATION

Name of Physician:

Physician Address: _____

City_____ TX, _____

Physician Phone Number: (_____)-_____-_____

Which hand does your child/adolescent show dominance? ☐ Left ☐ Right ☐ No preference

Does your child/adolescent have any current health conditions, including infectious diseases?
☐ Yes ☐ No
* If yes, please explain below.

Known Medical Conditions	Dates and Providers of Previous Treatment	Current Treating Clinicians	Current Therapeutic Intervention and Reasoning

Please also provide the following:
List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child/adolescent has had.

Does your child/adolescent have any vision problems? ☐ Yes ☐ No
* If yes, please explain below and if there are any treatments currently being used for correction.

Does your child/adolescent have any hearing problems? ☐ Yes ☐ No
* If yes, please explain below and if there are any treatments currently being used for correction.

Does your child/adolescent have a history of seizures? ☐ Yes ☐ No
* If yes, please describe the types of seizures and current treatment.

Is your child/adolescent currently taking any medications? ☐ Yes ☐ No

* If yes, please provide the following information:

Name of Medication	Amount	How often is the medication taken?	When is the medication taken?	Please state any reactions or side effects your child/adolescent experiences from the medication.

Does your child/adolescent have any allergies to medications? ☐ Yes ☐ No

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

Does your child/adolescent have any other allergies (seasonal, food, etc.)? ☐ Yes ☐ No

* If yes, please describe, including any adverse reactions and if any epi pen is needed:

Does your child/adolescent currently have a diagnosis? ☐ Yes ☐ No

* If yes, please provide the following information:

Diagnosis	Diagnosing Physician	Date Diagnosed	Diagnosis Code

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

INSURANCE INFORMTION

Name of Insurance Company:

Name of Policy Holder:

Social Security #: _____-_____-_____ Date of Birth _____-_____-_____

Insurance Address

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

CURRENT/PREVIOUS THERAPY PROVIDER INFORMATION

Please provide us with information regarding the following types of current or previous therapy providers and copies of any recent evaluations that indicate dates of previous treatment and therapeutic interventions and responses.

Does your child/adolescent currently receive behavioral services with another provider?

- ☐ Yes
- ☐ No

Name of **Behavioral Provider**:

Provider Address:

Provider Phone Number: (_____)- _____-_____ Email: _____

Does your child/adolescent currently receive speech therapy services

☐ Yes (Please provide information below)

☐ No

Name of Speech Therapy Provider:

Provider Address:

Provider Phone Number: (_____)-_____-_____ Email: _____

Does your child/adolescent currently receive occupational therapy?

☐ Yes (Please provide information below.)
☐ No

Name of Occupational Therapy Provider:

Provider Address:

Provider Phone Number: (_____)-_____-_____ Email: _____

Does your child/adolescent currently receive physical therapy services?

☐ Yes (Please provide information below)
☐ No

Name of Physical Therapy Provider:

Provider Address:

Provider Phone Number: (_____)-_____-_____Email: _____

Does your child/adolescent currently receive psychiatric services?

☐ Yes (Please provide information below)
☐ No

Name of Psychiatric Provider:

Provider Address:

Provider Phone Number: (_____)-_____-_____ Email: _____

Does your child/adolescent currently receive any other services?

☐ Yes (Please provide information below)
☐ No

Name of Other Provider:

Provider Address:

Provider Phone Number: (_____)-_____-_____Email: _____

EDUCATIONAL HISTORY

Please list all schools our child/adolescent has attended in order starting with the most current school.

Name of School	School System	Year(s)	Grade	Special Education Services
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Is your child/adolescent currently classified for special education services? ☐Yes ☐No

**** Please provide us with copies of any reports from evaluations that you may have, as well as a copy of the current 504 plan or IEP.***

FAMILY BACKGROUND

Does either parent/guardian's job require him/her to be away from home for long hours or extended periods of time that might prevent them from being involved in ABA services and parent training?

☐Yes ☐No

* If yes, which parent/guardian and for how long?

Marital Status:

☐ Married
☐ Civil Union
☐ Remarried
☐ Divorced
☐ Separated
☐ Widowed
☐ Single
☐ Cohabitants

* If divorced, who has legal custody? Is it full or joint custody?

Are there siblings? ☐Yes ☐No

If yes, please provide the following information:

	Name	Age	Relationship	Living in Home?	School	Grade
1.				☐ Yes ☐ No		
2.				☐ Yes ☐ No		
3.				☐ Yes ☐ No		

Please indicate and describe whether any of the siblings have any special needs, diagnoses, or concerns.

Are you also interested in seeking services for any of the siblings with special needs?

☐ Yes ☐ No ☐ Not applicable

*If yes, you will need to complete a new intake packet for that child.

Are there any other individuals residing in the house or that play a significant role on how this child is raised?

☐ Yes ☐ No

* If yes, please identify who else is involved in raising the child and their relationship to the child.

PSYCHOLOGICAL HISTORY

Please indicate below whether there is a history of the following in your immediate family or in either biological parent's extended family.

Yes	**No**	
☐	☐	Autism Spectrum Disorders
☐	☐	Learning Problems/Disabilities
☐	☐	ADD/ADHD-Attention Problems
☐	☐	Clinical Depression
☐	☐	Bipolar Disorder
☐	☐	Behavior Problems in School
☐	☐	Anxiety Disorders (e.g., OCD, etc.)
☐	☐	Intellectual Disability
☐	☐	Psychosis/Schizophrenia
☐	☐	Substance Abuse/Dependence

Other Mental Health Concerns (Please specify):

If yes, please indicate who in the family currently has or has had these diagnoses:

Has your child/adolescent had an outside psychological or psychiatric evaluation? ☐Yes ☐No

Has your child/adolescent ever been hospitalized for a psychiatric condition? ☐ Yes ☐ No

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

BIRTH AND DEVELOPMENTAL HISTORY

Did the birth mother receive regular prenatal care? ☐ Yes ☐ No

Were there any complications with the pregnancy? ☐ Yes ☐ No

* If yes, please describe the complications below and treatment details.

Was birth at full term? ☐ Yes ☐ NO

* If no, please provide details.

What was the type of delivery? ☐ Spontaneous ☐ Induced ☐ Vaginal ☐ C-Section

Were there any complications during delivery? ☐Yes ☐ NO

* If yes, please describe the complications below and treatment details.

What was your child/adolescent's birth weight? lbs. oz.

Were there any concerns at birth? ☐ Yes ☐ No

* If yes, please describe the concerns and treatment details.

Were there any developmental milestones that your child was delayed in or did not achieve?

☐ Yes ☐ No

* If yes, please identify those milestones below.

CURRENT BEHAVIORAL CONCERNS

Please indicate if your child/adolescent engages in any of the following behaviors (check all that apply):

- ☐ Aggression (specify below)
  - ☐ Hitting (e.g., punch, slap, etc.)
  - ☐ Kicking
  - ☐ Biting
  - ☐ Pinching
  - ☐ Head-butting
  - ☐ Scratching
  - ☐ Spitting
  - ☐ Other (Please specify):
- ☐ Self- Injurious Behavior (specify below)
  - ☐ Hitting self with hands or fists (Where on body?)
  - ☐ Kicking self (where on body?)
  - ☐ Biting self (where on body?)
  - ☐ Head-butting walls, windows, etc.
  - ☐ Pulling teeth
  - ☐ Scratching skin
  - ☐ Cutting/burning
  - ☐ Other (Please specify):
  - ☐ Property Destruction (describe):
- ☐ Eloping (i.e., running out of building, room, vehicle, etc.)
- ☐ Sensory issues (please describe):
- ☐ Sexualized behavior (please describe):
- ☐ Self-urinating/defecating
- ☐ Fecal Smearing
- ☐ Rectal digging
- ☐ Difficulty with toileting
- ☐ Defiance or problems with authority
- ☐ Problems with eating
- ☐ Tantrums
- ☐ Screaming/yelling
- ☐ Vocalization
- ☐ Repetitive Behaviors
- ☐ Other (please specify):

Additionally, please indicate if your child is experiencing any of the following (check all that apply)

- ☐ Isolated socially from peers
- ☐ Difficulty making friends
- ☐ Problems keeping friends
- ☐ Sleep problems (describe:)
- ☐ Bedwetting
- ☐ Fire setting
- ☐ Anxiety
- ☐ Sadness or depression
- ☐ Hallucination
  - ☐ Delusions
- ☐ Suicidal ideation/attempts

- ☐ Legal situations
- ☐ History of physical abuse
- ☐ History of sexual abuse
- ☐ Alcohol use/abuse
- ☐ Drug use/abuse including nicotine and/or illegal drugs (list drugs):
- ☐ Difficulty concentrating

Are there any current or past relevant legal issues pending with your child/adolescent?

☐Yes ☐ NO * If yes, please describe below.

Please state the goals that you have for Your child/adolescent while engaging in a behavioral program.

DISCIPLINE INFORMATION

Please rate what percentage of discipline is handled by each of the following:

Parent/Guardian l: %Relationship to Child/Adolescent:

Parent/Guardian 2: % Relationship to Child/Adolescent:

What is typically used for disciplining your child/adolescent (e.g., timeout, assigning chores, physical/corporal punishment, etc.)?

Are there any spiritual beliefs or values that you think may impact how you provide discipline or behavioral supports to your child? ☐Yes ☐ No * If yes, please describe below.

Are there any cultural beliefs or values that you think may impact how you provide discipline or behavioral supports to your child?
☐Yes ☐ No * If yes, please describe below.

PHOTO RELEASE PERMISSION FORM

Marigold Learning Academy ABA Therapy Center is requesting your permission to use any pictures taken of your child, whether a snap-shot or professionally done, for advertising purposes, We advertise locally through magazines, business directories, through our website, Facebook, etc. If you feel comfortable with your child's picture being used to advertise for us, then please fill out the bottom portion and return it with your completed registration paperwork. Thank you for considering this opportunity for us to show off your child's beautiful face!

I, _____ am the parent / legal guardian (circle one) of

_____ I fully give my permission for Marigold Learning Academy

ABA Therapy Center to use my child's picture for any advertising purposes, this includes, but not limited to, magazines ads, business directories, flyers, and the center's website. I understand that photographs of my child can or will be used currently or after enrollment at

Marigold Learning Academy ABA Therapy Center.

_____ ____/____/____

Please print your child's name DOB

_____ ____/____/____

Parent Signature Date

(Disclaimer: Please know that some classes choose to use children's pictures for various arts, gifts, table tags, and cubby or door decorations. All advertising done for Marigold Learning Academy ABA Therapy Center will be done in a professional and tasteful manner. There will be no exploiting, misuse, or improper manner of picture advertisement,)

UPDATED NOTICE OF PRIVACY PRACTICES
HIPAA Compliance Statement

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

Understanding Your Health Information

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

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

Your Health Information Rights

Although your health record is the physical property of MLA the information belongs to you. You have the following rights:

A. Right to Request a Restriction

You have the right to request a restriction on our use and sharing of you protected health information. MLA can deny the request if it is unreasonable or would be detrimental to your treatment.

B. Right to a Paper Copy of this Notice

You have a right to obtain a paper copy of this notice.

C. Right to Amend Your Health Information

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

Health Care Insurance Providers

If we do not file your insurance claims at this time, we will provide you with statements that you may submit to your insurance carrier or complete any forms as required by your insurance carrier in order to obtain reimbursement for out-of-network providers. In order to assist you with obtaining reimbursement for our services, your insurance carrier may require that we provide a clinical diagnosis, or additional clinical information such as treatment plans or summaries, or copies of your child's entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Although all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. We will provide you with a copy of any report or form that we submit upon your request. By signing this Notice, you agree that we can provide requested information to your carrier for authorization of services and if/when you choose to file a claim for any services that we have provided to you or your child.

Others We May Share Your Information With

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

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

Records

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

Legal Proceedings

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

Confidentiality, Records, and Release of Information

Behavioral services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions and as mandated by MLA and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

To Protect the Client or Others from Harm

If we have reason to suspect that a minor, elderly, or person with a disability is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions, which could include but not limited to, notifying the police or an intended victim, a minor's parents, or others who could provide protection, or seek appropriate hospitalization.

Professional Consultations

Board Certified Behavior Analysts and other professionals providing ABA services will routinely consult about cases with other professionals. Therefore, we make every effort to avoid revealing the identity of our clients and any consulting professionals are also required to refrain from disclosing any information we reveal to them. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

Your Authorization is Required for Other Uses of Protected Health Information

MLA is required by law to:

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

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

WE WILL NOT USE OR DISCLOSURE YOU/YOUR CHILDS'S PROTECTED HEALTH INFORAMTION WITHOUT YOUR AUTHORIZATION, EXCEPT AS DESCRIBED IN THIS NOTICE.

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

CONSENT

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

Your signature(s) below indicated that you have read the information in this document and agree to be bound by its terms, and that you have received the above-mentioned HIPAA notice form described above. Consent by all parents/legal guardian's (those with legal custody) is required.

Parent/Guardian #1: _____
(print name)

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

Parent/Guardian #2: _____
(print name)

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

Marigold
Learning Academy
& ABA Therapy Center

REINFORCER CHECKLIST TEMPLATE

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

Edible Reinforcers

- ☐ Yes
- ☐ No

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

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

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

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

_____

Tangible Reinforcers

- ☐ Yes
- ☐ No

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

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

Rockwall: 401 W Washington St., Rockwall TX, 75087 *Greenville: 2300 Joe Ramsey Blvd. Ste B, Greenville TX, 75041*
Phone: 972-722-3892 *Fax: 214 -602-2729*

Social Reinforcers

- ☐ Yes
- ☐ No

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

- ☐ Interacting with parents/guardians:
- ☐ Interacting with siblings:
- ☐ Interacting with other family members:
- ☐ Interacting with friends:
- ☐ High fives
- ☐ Verbal praise
- ☐ Other (please specify):

Activity Reinforcers

- ☐ Yes
- ☐ No

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

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

Automatic Reinforcers

- ☐ Yes
- ☐ No

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

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

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

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TREATMENT CONTRACT

I/We are entering into this contract with Marigold Learning Academy ABA Therapy Center (MLA) voluntarily. This contract will remain in effect from this date, _____/_____/_____, until either party wishes to terminate this agreement by giving written notice.

I/We agree to cooperate with MLA's efforts to provide services to my child and my family and I/we will participate in the treatment process and will follow through with any interventions recommended by Karri Shojaei-Scott, BCBA. I/We understand that failure to comply with treatment and/or participate in parent training may be grounds for dismissal and termination of ABA services.

Karri Shojaei-Scott, BCBA. will supervise and monitor services provided to me and my child by individual therapists and consultants. These therapists and consultants are employees of MLA and will be supervised accordingly.

I/we understand that Karri Shojaei-Scott, BCBA. shall have exclusive responsibility and authority to make all professional judgments and decisions with reference to the services rendered to me/us and our family.

I/we understand that a minimum of hours per week of supervision by a Board-Certified Behavior Analyst is required to properly supervise the program, observe my child engaging in the recommended program, and make changes to his/her program. Additionally, that I/we must participate in a progress meeting every 12cweeks to review my child's progress and to discuss any changes to my child's program.

I/we understand that MLA will incur substantial costs in providing and arranging for the services to be provided to our family, including supplies, services, personnel, and other items that are subject to this agreement. Accordingly, I/we promise and agree that, during the term of this agreement, and any extension to the agreement, plus one (l) year after the agreement expires, is terminated, or otherwise concludes:

1. I/We will not attempt to directly or indirectly own, manage, operate, control, or participate in the ownership, management, operation or control of, or become associated, as an employee, director, officer, advisor, agent, consultant, principal, partner, member or independent contractor with any person, enterprise, firm, partnership, corporation, limited liability entity, cooperative, or other entity operating a behavioral consulting services firm or other competitive business located, or providing services, within a twenty (20) mile radius of the areas where MLA provides services.
2. I/We will not attempt to divert any business of MLA to any other competitive establishment that is located within a twenty (20) mile radius of the areas where MLA provides services.
3. I/We agree not to solicit or employ any employee or independent contractor of MLA, including Board Certified Behavior Analysts, consultants, therapists, or any other employees, in any manner including, but not limited to, as an employee, consultant, or through a third party, other than general advertisement without prior written approval by MLA during the term of this agreement and for at least one (l) year after the expiration, termination, or conclusion of this agreement. Unless otherwise agreed to by the Parties, if I/we violate this Section, I/we agree

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4. to pay a fee of fifty percent (50%) of the gross annual salary paid by MLA to such employee or independent contractor, including Board Certified Behavior Analysts, consultants, and therapists.
5. Such fee shall be paid by me/us upon hiring of such employee or independent contractor, including Board Certified Behavior Analysts, consultants, and therapists, in any capacity.
6. I/We agree to maintain confidentiality for all business policies, procedures, techniques, trade erects, other knowledge, or processes developed by MLA. I/We understand that all program materials are

   prepared solely for my/our use and cannot be copied, disseminated, published, or shared with a third party without the approval of MLA. I/We understand that all program materials must be returned to MLA upon termination of this agreement.

I/We understand that there is a risk associated with any type of therapy or intervention, however, MLA does everything possible to minimize risks. I/We agree that to the fullest extent permitted by law, MLA shall not be liable to the Client for any special, indirect, or consequential damages whatsoever, whether caused by MLA's negligence, breach of contract, or other cause or causes whatsoever including, but not limited to, loss of behavioral consulting services and the costs related to locating a new provider of such consulting services. This does not include willful or intentional wrongs. I also understand that therapy outcomes are dependent on several variables and success cannot be guaranteed. I understand that failure to adhere to treatment recommendations by MLA staff may impact the success of my child's progress and that I am responsible for being a willing and active participant in this process. I understand that continual noncompliance with adhering to treatment recommendations may result in termination of services.

Executed this _____day of _____, _____.

Parent/Guardian# 1: _____
(Print Name)

Parent/Guardian #1: _____ Date: _____/_____/_____

(Signature)

Parent/Guardian #2: _____
(Print Name)

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

Service Provide

Name of Owner/Clinical Director: _____
(Print Name)

Owner/Clinical Signature: _____ Date: _____/_____/_____
(Signature)

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