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BEHAVIORAL CONSULTING LLC

# CONSENT FOR APPLIED BEHAVIOR ANALYSIS SERVICES

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

I, _____, agree to have my child/dependent, _____, participate in applied behavior analysis (ABA) assessment and/or treatment services provided by Joseph Adams BCBA at Adams Behavioral Consulting LLC. I understand that the specific activities, goals, and desired outcomes of these ABA services will be fully discussed with me and that I will have the opportunity to ask for clarification prior to signing this document. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation in services. If these services have been arranged or will be paid for by a third party (e.g., school, insurance plan, state agency), I am aware of the rights of the third party. I also understand that my child/dependent is the primary client of the behavior analyst and that services will be designed primarily for CLIENT'S NAME's benefit. Any other individuals or agencies (e.g., family, school professionals) who may be affected by the ABA services are considered secondary clients.

If the ABA services focus on increasing _____'s skills, I understand that the first several sessions will consist of assessment activities designed to (a) evaluate his/her current skills (e.g., curricular assessments) and (b) determine which instructional strategies and interventions are likely to prove most effective (e.g., preference assessments, assessment of prompting strategies). The time allocated to these assessments will result in improved intervention. If the services are designed to improve ongoing problem behaviors, I understand that the beginning of those services will include functional assessment and/or functional analysis activities (e.g., interviews, checklists, direct observations) that are designed to provide information critical to the development of effective treatment procedures. I may be asked to assist in gathering some of this information by recording problem behavior as it occurs. This process may take additional time to complete prior to implementing intervention but will increase the likelihood of effective intervention. The subsequent services will be focused on development of and implementation of instructional procedures and/or a behavior intervention plan. Prior to implementation, I will receive a printed copy of the results of any assessment and of any proposed instructional procedures or behavior intervention plans for my approval. The contents of those documents will be explained to me fully and any questions I have will be answered to my satisfaction. Subsequent implementation will involve training in the basics of ABA that are important for the intervention, details about the specific components of the ABA intervention, and direct practice in the components for the family, educators, and/or other service provider. Parent/caregivers are required to participate in training activities as written in the treatment plan. Full participation in these implementation and training activities is critical for a successful outcome. Ongoing collection of data will allow evaluation of the effectiveness of the intervention and will assist in developing any revisions that need to be made to ensure a good outcome. When the goals we have established are achieved; we will discuss the discontinuation of services as we will have achieved our therapeutic objectives. In addition, at regular progress reviews we may also discuss whether continuation of services would be beneficial, and any barriers to continuation. Behavior analysts are ethically obligated to provide treatments that have been scientifically supported as most effective for Autism Spectrum Disorders and other related developmental diagnosis or ADHD. I am aware that other non-evidence-based interventions that I am pursuing may affect my child's response to ABA treatment. Thus, it is important to make

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the behavior analyst aware of those interventions and to partner with the behavior analyst to evaluate any associated therapeutic or detriment effects of those interventions.

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

I understand that _____ assessment and treatment services may be observed by supervisors or other employees as part of ongoing training and quality assurance activities. Events occurring in those sessions will be discussed in closed supervision meetings of Adams Behavioral Consulting LLC. All individuals attending these staff meetings are bound by the same confidentiality guidelines as your provided in order to protect my privacy and that of my child/dependent. I am aware that a record of the treatment will be maintained, and this record is available to me in written form upon request.

I understand that it may be necessary to audio- or videotape assessment and/or treatment sessions for supervision or diagnostic purposes. In the event that audio- or videotaping is necessary, I will be informed and asked to give written consent prior to taping. If the assessment or treatment involves formal research that goes beyond normal evaluation or clinical procedures, I reserve the right to consent or refuse to participate.

I understand that if therapy services are provided in the home or community setting that a guardian or parent must be present for the entire duration of the session. I reserve the right to withdraw at any time from these services and I understand that such a withdrawal will not affect _____'s right to services. In the event of withdrawal, I may request a list of other credentialed providers in the region. In addition, I reserve the right to refuse, at any time, the treatment that is being offered.

I am aware that the relationship between provider and client is a professional one that precludes ongoing social relationships, giving of gifts, or participation in personal events such as parties, graduations, etc. I may request a copy of my provider's current professional credentials upon request.

These policies have been fully explained to me, and I fully and freely give my consent and permission for my dependent.

_____ _____
Parent's/Legal Guardian's Signature Date

_____ _____
Parent's/Legal Guardian's Signature Date

_____ _____ _____
Board Certified Behavior Analyst Signature BCBA Certificate # Date

Please initial that you have read this page _____

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# INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Welcome to Adams Behavioral Consulting LLC, we look forward to working with you. This document contains important information about our professional services and business policies at Adams Behavioral Consulting LLC. Also, you will be expected to read and sign our Health Insurance Portability and Accountability Act (HIPAA) form. HIPAA is a federal law that provides 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 healthcare operations. HIPAA requires that as your behavioral/behavioral health professional, I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. Law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. Please note any questions you might have so that we can discuss them.

**PSYCHOLOGICAL/THERAPEUTIC/COUNSELING SERVICES:**
Therapy is not easily described in general statements as it varies depending on the particular problems you are experiencing. There are many different methods used to deal with the problems that you hope to address. Therapy is not like a medical doctor visit as it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Since therapy often involves discussing unpleasant aspects of your life or your child's, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another behavioral health professional for a second opinion. Adams Behavioral Consulting, LLC offers multiple evidence-based types of individual and group ways to meet the diverse needs of each client. At your intake appointment, your provider will discuss an individualized treatment plan for you or your child.

**APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES:**
At Adams Behavioral Consulting LLC, our Board Certified Behavior Analysts (BCBA) offer individualized ABA services for children from infancy to 21 years of age with a diagnosis of Autism Spectrum Disorder. Treatment can be provided in the clinic, home, school and community settings based on your child's needs and behavior analyst recommendation. The goals of intervention is not only to improve behavior, but also to enhance the overall quality of life for children and families. ABA is a set of principles that form the basis for many behavioral treatments and includes many different techniques. All of these techniques focus on antecedents (what happens before a behavior occurs) and on consequences (what happens after the behavior). A few types of therapies based on ABA principles are Discrete Trial Training (DTT), Analysis of Verbal Behavior (AVB), and Natural Environment Training (NET), Functional Behavior Assessments (FBA) and Social Skills Training. We will discuss and determine the best course of treatment to meet your child's needs. We usually schedule 1-5 therapy appointments per week at a time we agree on. Sessions range from 2 hours to 5 hours. Our clients typically benefit from 10-30 hours per week of therapy. You may be asked to bring your child in during school hours. Arrangements can be made with school administrators for therapy sessions.

**APPOINTMENTS AND CANCELLATIONS:**
24 hours' notice is required of your intent to cancel an appointment. If you cancel an appointment without 24 hours' notice, or if you no-show for an appointment, you will be charged the full amount of the session. These charges are not covered by insurance, it is the patient's responsibility and is due within one week of the missed appointment. After two missed appointments without 24 hours' notice, you may be terminated as a patient and will be provided with referral options. It is your responsibility to remember your appointment time. I am happy to provide you with an appointment reminder if requested.

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**BILLING AND PAYMENTS:**
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested if your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon Adams Behavioral Consulting, LLC has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require us to disclose otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, nature of services provided, and the amount due. If such legal action is necessary, its costs will be included.

**INSURANCE REIMBURSEMENT:**
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for behavioral health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you are ultimately the party responsible for full payment of my fees. It is very important that you find out exactly what behavioral health services your insurance policy covers. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can. If necessary, we will be willing to call the company on your behalf. You should also be aware that your contract with your health insurance company often requires that your therapist provide them with information relevant to the services that you receive at Adams Behavioral Consulting, LLC in such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. By signing this Agreement, you agree that I can provide requested information to your carrier. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you have the right to pay for services yourself to avoid the problems described above.

**CONTACTING YOUR BCBA AT ADAMS BEHAVIORAL CONSULTING, LLC:**
Due to our work schedule, your BCBA may not be immediately available by telephone. Our voicemail system is checked for messages regularly during normal business hours. Messages left on weekends or holidays will be returned the following business day. Occasionally, messages get lost or are not received, so if you have not received an expected return call, you will need to call again. If you are difficult to reach, please inform me of sometimes when you will be available. We do not text with clients.

**Area of Service:**
Adams Behavioral Consulting, LLC offers ABA therapy within the counties of Rockale, Newton, Clayton, Dekalb, and Putnam. Exceptions to the above-mentioned counties can be discussed on a case-by-case basis with the BCBA.

**EMERGENCIES**:
The practice of private outpatient therapy with children and adults makes the assumption that clients are functioning, self-responsible individuals with legitimate pain and legitimate needs. Private outpatient therapy cannot, by its structure, assume responsibility for day-to-day functioning of its clients in the same way agencies and institutions can. With this philosophy in mind, I attempt to operate my practice in a way that is responsible to your needs, encouraging of your autonomy, and respectful of our limits. During weekdays, we will make every effort to return phone calls within 24 hours, and weekend calls will be returned by Monday or the first business day after a holiday weekend, barring personal emergency, or planned out-of-town absences. If you have a behavioral health emergency, please contact or go to your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call or call 911. If your therapist is expected to be unavailable for an extended period of time, they will let you know in advance and will, if requested, provide you with the name of a trusted colleague whom you can contact during their absence.

Please initial that you have read this page _____

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**INCLEMENT WEATHER PLAN:**
We follow Putnam System in terms of office closings. If schools in Rockdale, Newton, Dekalb and Clayton, Putnam, we will be closed. Updates regarding the status of all appointments will be Dispersed by email, phone call. If the local phone service is not available, it can be assumed that your appointment will need to be rescheduled at a later time.

**CONFIDENTIALITY:**
With the exception of specific exceptions described in our HIPAA form, you have the absolute right to the confidentiality of your treatment. In general, the law and ethics of the psychological/counseling and behavior analyst profession protects the confidentiality of all communications between a client and his/her therapist, and the therapist may only release information about the sessions to others with your written permission. We take your confidentiality very seriously and work hard to ensure that information is shared only with your consent and awareness. You should know, however, that information might sometimes be shared with other professionals in our agency (supervisors, clinical review team). This is done only when necessary and relevant to your clinical needs. All persons involved in the supervision of interns are fully licensed and bound by the same laws and ethics of confidentiality that your therapist adheres to. Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my office or as a secure electronic record. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

**PROFESSIONAL RELATIONSHIP:**
ABA therapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the behavioral health profession. Dual relationships can set up conflicts between the BCBA's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my patients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature. You should also know that BCBA's are required to keep the identity of their patient's secret. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. I am not allowed to accept any gifts. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

**STATEMENT REGARDING ETHICS, CLIENT WELFARE & SAFETY:**
I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the Behavior Analyst Certification Board. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the Georgia professional licensing board that governs my profession. Due to the very nature of therapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am

unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life.

**TECHNOLOGY STATEMENT:**
In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional. Therefore, I've developed the following policies:

**Cell phones:** It is important for you to know that cell phones may not be completely secure and confidential. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with me.

**Text Messaging and Email:** Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. It is the policy of Adams Behavioral Consulting, LLC to never communicate with patients using text messages, with the exception of automated appointment reminders. You also need to know that I am required to keep a copy of all emails as part of your clinical record.

**Facebook, LinkedIn, Etc.:** It is my policy not to accept requests from any current or former client on social networking sites such as Facebook or LinkedIn because it may compromise your confidentiality. Currently, Adams Behavioral Consulting LLC does not have a business Facebook page, a Twitter account and is not on LinkedIn. You are welcome to follow me on any of these pages. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Adams Behavioral Consulting, LLC If you would like to follow me on any of these media, you might want to consider using an alias to keep your connection with me confidential, but that is entirely your decision. In summary, technology is constantly changing, and there are implications to all of the above that I may not realize at this time. Please feel free to ask questions and know that I am open to any feelings or thoughts you have about these and other modalities of communication. If you have any questions about any part of this document, please ask. Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with me as your therapist, and you are authorizing me to begin treatment with you and/or your child.

| Client Name | Client Signature | Date |
|---|---|---|

| Parent/Legal Guardian Name | Parent/Legal Guardian Signature | Date |
|---|---|---|

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

| BCBA Name | BCBA Signature | Date |
|---|---|---|

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# GEORGIA HIPAA NOTICE

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Georgia State Laws.

**THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION UNDER THE NEW HIPPA LAWS. PLEASE REVIEW IT CAREFULLY.**

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

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- "Payment" is when I obtain 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" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office such as sharing, employing, 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.

**II. Uses and Disclosures Requiring Authorization:**

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your ABA Therapy Notes. "ABA Therapy Notes" are notes I have made about our conversation during a direct care, family training, or social skills session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

**III. Uses and Disclosures with Neither Consent nor Authorization:**

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

- Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- Health Oversight – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.
- Judicial or Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Worker's Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

**IV. Patient's Rights and Psychologist's Duties:**

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive 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 at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your 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 in my behavioral health and billing records used to make decisions about you for as long as the PHI is maintained in the record. An appointment will be scheduled to review these records in my presence so that any issues can be discussed. Normal hourly and/or copying changes will apply. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial 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. I may deny your request. Upon 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. Upon 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 the notice from me upon request.

**BCBA's Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you at the mailing address you provided.

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**V. Complaints:**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me at 404-808-7246 or via U.S. mail at 1603 Manchester Dr, Conyers Ga. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**VI. Restrictions:**

I will limit the uses or disclosures that I will make as follows:

- I will not release the contents of "Psychotherapy Notes" under any circumstance with the following exceptions:
    I. If you file a lawsuit or ethics complaint against me, I may release "Psychotherapy Notes" for use in my defense.
    II. When the following "Uses and Disclosures with Neither Consent nor Authorization" apply:
    III. Child Abuse
    IV. Adult and Domestic Abuse
    V. Health Oversight
    VI. Judicial or Administrative Proceedings
    VII. Serious Threat to Health or Safety

Please discuss any questions or concerns with your therapist. Your signature below indicates that you acknowledge receipt of this notice:

| Client Name | Client Signature | Date |
|---|---|---|

*If Applicable:*

| Parent/Legal Guardian | Parent/Legal Guardian Signature | Date |
|---|---|---|

Please initial that you have read this page _____

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# PATIENT AGREEMENT FOR COMMUNICATIONS

I, _____, Understand that as part of my health care Adams Behavioral Consulting, LLC. will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I hereby authorize Adams Behavioral Consulting LLC. to contact me in the following ways:

Phone #: _____

Home voice mail #: _____

Office voice mail #: _____

Email: _____

Fax: _____

Text: _____

I understand that Adams Behavioral Consulting, LLC. will use the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already complete.

_____ _____

Parent's/Legal Guardian's Signature Date

Please initial that you have read this page _____

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BEHAVIORAL CONSULTING LLC

# NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

**For Treatment, Payment, or Healthcare Operations**

I, _____, understand that as part of my health care, Adams Behavioral Consulting LLC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted areas. I fully understand and accept the terms of this content.

_____ _____

Parent's/Legal Guardian's Signature Date

Please initial that you have read this page _____

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# AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION (PHI)

I, _____ (Patient Name), _____ (Date of Birth)
hereby provide full consent and authorization to:

Adams Behavioral Consulting and Joseph Adams M.Ed BCBA., its affiliates, employees, agents and assigns and the following party, or parties, listed below to release and discuss my behavioral health and /or medical treatment information by providing and disclosing HIPAA protected records obtained in the course of psychological evaluation and therapy, medical services, prescription management, psychiatric evaluation and treatment, diagnostic testing, laboratory testing, Applied Behavior Analysis services, and neurofeedback, including, but not limited to diagnosis and all clinical information about me as may be necessary to monitor the continuity of my care, claims/benefit management, patient account management and related health care services. This to inform individuals/entities listed below of my behavioral health and/or medical status and may include information that identifies my name, social security number and member ID number. Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Name of Provider/Facility/Entity/Physician: Adams Behavioral Consulting
Address: 1603 Manchester Dr SW
Phone: 404-808-7246

Please indicate your preference regarding the information to be shared:

☐ The parties stated above have my full consent and authorization to discuss my complete medical and/or behavioral Protected Health Information (PHI) record as indicated above with no limitations, restrictions or exceptions.

☐ I would prefer to limit the information shared between the parties stated above. The limitations, restrictions or exceptions are:

| |
|---|
| |

I understand that my treatment or related services will not be conditioned on whether I sign this authorization. Additionally, the above-named parties, agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality. Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless Adams Behavioral Consulting LLC stated above has taken action in reliance upon it. This authorization becomes effective on the date below and automatically expires within (1) year of its effective date. I understand that this authorization does not extend to the release of any AIDS/HIV information unless I have Additionally, if you decide to revoke this authorization, such revocation must be in writing by the above-named provider at Adams Behavioral Consulting, 1603 Manchester Dr SW, Conyers, GA 30094.

_____ _____

Parent's/Legal Guardian's Signature Date

Please initial that you have read this page _____

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# CONSENT FOR TREATMENT WITH BCBA

Patient Name: _____

I, _____, authorize and request Joseph Adams, may carry out Applied Behavior Analysis which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me and be subject to my agreement.

I, _____, hereby give my written consent to have the BCBA disclose any medical, psychological or personal information concerning me, or my child to their supervisors. This authorization may be revoked at any time by written notification to Adams Behavioral Consulting, LLC.

I have read and fully understand this Consent for Treatment Form.

_____ _____

Client/Guardian Signature Date

_____ _____

BCBA Signature Date

Please initial that you have read this page _____

# Telemedicine Member Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

GA MED ID#: _____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s):

| |
|---|
| |

2. **NATURE OF TELEMEDICINE CONSULT:** During the telemedicine consultation:
   a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medic al technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telemedicine consultation.
5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **DISPUTES:** You agree that any dispute arriving from the telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.
7. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered and you understand the written information provided above.

I agree to participate in a telemedicine consultation for the procedure(s)described above.

Signature: _____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

Witness Signature: _____ Date: _____

1603 Manchester Dr Sw, Conyers, Ga 30094 p: 404-808-7246  e: adamsbehavioralconsulting@gmail.com

# In-Home Adams Behavioral Consulting Intake Packet

Thank you for selecting Adams Behavioral Consulting LLC,  to help you meet the needs of your child. We know you have many options to choose from and appreciate your having selected us to assist you with this important process.

The attached packet of information will help inform you about Adams Behavioral Consulting LLC policies and procedures and allow you time to gather information prior to your intake appointment. This information will be shared with the BCBA assigned to your case, should you proceed with ABA therapy, prior to your initial meeting with them. In each instance the BCBA is responsible professionally for all services provided to you and your child.

Thank you for the trust that you are placing in us to assist you and your family. We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information that we have the better we will be to assist you and your family. If at any time in this process you have any questions, please contact us.

I look forward to meeting with your child,

Joseph Adams, M.Ed, BCBA

# What is Required to Start In-Home ABA Services?

## 1. Completed In-take Packet

- Child & Adolescent Intake Questionnaire
- HIPPA Service Agreement and Consent Form
- Patient Confidentiality Contact Form
- Medicaid Coverage Statement
- Payment Policy Form
- Request/Authorization to Release Confidential Medical & Mental Health Records and Information (Optional – as needed)
- Documentation of Custody, if relevant.

# CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

**Confidential** The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding your child. Adams Behavioral Consulting, LLC will hold information provided by you as strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information.

Name of Person Completing this form: _____

Legal Name of Child/Adolescent: _____

Nickname or name child routinely goes by: _____

Child's Date of Birth: _____ Age: _____

Home Address:

_____

Street City State Zip

Cellular Phone(s): _____ Preferred Email:_____

School Name: _____ System:_____ Grade: _____

School Telephone Number: _____ Contact Person: _____

Current Teacher(s):

| |
|---|
| |

Who referred you to our office? _____

Please describe the problems your child is now having, and what type of services you are seeking from us for these problems. Please use the back of this page for additional space.

| |
|---|
| |

**INDICATE PARENTS/GUARDIANS LIVING IN THE HOME:**

Marital Status: Married Remarried Divorced Separated Widowed Single Cohabitants

- If divorced, who has physical custody? _____ Is it full or joint? _____
- Who has legal custody? _____ Is it full or joint? _____
- If divorced, please provide a copy of the custody agreement.

Mother's Name_____

Date of Birth: _____ Age: _____ Occupation: _____

Employer: _____ Education Completed_____

Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Father's Name_____

Date of Birth: _____ Age: _____ Occupation: _____

Employer: _____ Education Completed_____

Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does either parent's job require him/her to be away from home long hours or extended periods?

_____

If married, how long have you been married? _____

If divorced, how long have the biological parents been divorced? _____

Has either parent been married before or since? Mother:_____ Father:_____

Please list the name(s) of the stepparents: _____

If yes, provide dates of previous marriage(s), names, and ages of children from these marriages:

Mother:_____ Children & Ages:_____

Father:_____ Children & Ages:_____

Is there a birth parent living outside the home: ☐ MOTHER ☐ FATHER

Name:_____ Where do they live_____

If birth parent(s) do not live in the child's home, how much contact does the child have with the parent not having custody, with stepsiblings, etc.?

**SIBLINGS: LIVING IN HOME**

| | Name | Age | Relationship | Home? | School | Grade |
|---|---|---|---|---|---|---|
| 1. | _____ | _____ | _____ | ☐ Y ☐ N | _____ | _____ |
| 2. | _____ | _____ | _____ | ☐ Y ☐ N | _____ | _____ |
| 3. | _____ | _____ | _____ | ☐ Y ☐ N | _____ | _____ |
| 4. | _____ | _____ | _____ | ☐ Y ☐ N | _____ | _____ |

• *Please list additional Siblings in the above format on the back of this page.*

Please indicate any concerns you have regarding the child for whom you are seeking services and these siblings relationship(s):

**PSYCHOLOGICAL HISTORY:**

Is there history in your immediate or mother's or father's extended family, of the following, and if so who?

| Yes | No | | Who |
|---|---|---|---|
| ☐ | ☐ | Autism Spectrum Disorders | _____ |
| ☐ | ☐ | Learning Problem/Disabilities | _____ |
| ☐ | ☐ | ADHD – ADD- Attention Problems | _____ |
| ☐ | ☐ | Depression & Manic-Depression | _____ |
| ☐ | ☐ | Behavior Problems in School | _____ |
| ☐ | ☐ | Anxiety Disorders (OCD, Phobias, etc.) | _____ |
| ☐ | ☐ | Mental Retardation | _____ |
| ☐ | ☐ | Psychosis/Schizophrenia | _____ |
| ☐ | ☐ | Substance Abuse/Dependence | _____ |
| ☐ | ☐ | Other Mental Health Concern (Please List) | _____ |

Has the child you are seeking services for been evaluated in the past? ☐ Yes ☐ No

If Yes, please list the following information on the previous evaluation(s):

| | Who/Agency Name | Type/Frequency/Length | Start/End Date |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |

**If more evaluations need to be listed please use the space on the back of this page.*

What were their general findings and recommendations?

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

**PRE-NATAL AND DELIVERY HISTORY:**

Did the birth mother receive regular pre-natal care? ☐ Yes ☐ No

If Yes, please provide treatment details:

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

If Yes, please provide details:

Was birth at Full Term? ☐ Yes ☐ No

If No, please provide details:

Type of Delivery: ☐ Spontaneous ☐ Induced ☐ Vaginal ☐ C-Section

Complications? ☐ Yes ☐ No

If Yes, please provide details:

Birth Weight: _____lbs _____oz Apgar Scores: _____ _____

Concerns at Birth? ☐ Yes ☐ No

If Yes, please provide details – including any treatments given (Additional space on back if needed):

Is there any additional pre-natal or birth information that might be of assistance to us?

Has your child ever had a fever above **104°**? ☐ Yes ☐ No

If yes, Please explain: _____

Has your child ever had a seizure of unexplained period of unconsciousness? ☐ Yes ☐ No

If yes, Please explain: _____

Has your child ever had a head trauma or blow to the head that cause unconsciousness or required a medical review? ☐ Yes ☐ No

If yes, Please explain: _____

**DEVELOPMENTAL HISTORY:**

1. Please indicate the age at which your child did the following:
   _____Rolled Over consistently
   _____Sat up unsupported
   _____Stood
   _____Crawled
   _____Walked Unassisted
   _____Said 1st Word Intelligible to strangers
   _____Said two-three word phrases
   _____Used Sentences regularly
   _____Toilet trained during the day
   _____Dry through the night (6+ months)
   _____Dressed Self

2. Please indicate if your child is experiencing any of the following:
   _____Problems with eating
   _____Isolated socially from peers
   _____Problems making friends
   _____Problems keeping friends
   _____Problems getting to sleep
   _____Problems controlling temper
   _____Problems sleeping through the night
   _____Trouble waking up
   _____Fatigue/tiredness during the day
   _____Nightmares
   _____Bed wetting
   _____Soiling
   _____Problems with authority
   _____Anxiety
   _____Unmotivated
   _____Stress from conflict between parents
   _____Legal situation (anyone in the family)
   _____History of abuse
   _____Alcohol/drug use/abuse
   _____School concentration difficulties
   _____Grades dropping or consistently low
   _____Sadness or Depression

3. List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

4. List any medications your child is currently taking or has taken for extended periods (give dates and dosage level, if possible):

5. Child's current height: _____Ft. _____Inches Weight: _____Lbs.

6. With which hand does the child write? _____

7. Does the child have any vision problems? _____
   Please list date of last vision test and who performed (pediatrician, optometrist, school)

8. Does the child have any hearing problems? _____
   Please list date of last hearing test and who performed (pediatrician, audiologist, school)

9. Name of child's physician(s) _____
   Practice Name: _____
   Address: _____
   Phone Number: _____ Fax Number: _____
   *(Please list information on additional Physicians on the back of the page)*

**EDUCATIONAL HISTORY:**

1. List in chronological order all schools your child has attended:

| | Name | System | Year(s) | Grade | Special Ed |
|---|---|---|---|---|---|
| 1. | _____ | _____ | _____ | _____ | ☐ Y ☐ N |
| 2. | _____ | _____ | _____ | _____ | ☐ Y ☐ N |
| 3. | _____ | _____ | _____ | _____ | ☐ Y ☐ N |
| 4. | _____ | _____ | _____ | _____ | ☐ Y ☐ N |

2. Name(s) of current teacher(s)_____

3. Does your child's teacher have concerns about him/her (list)

| |
|---|
| |

4. What is your child's favorite subject/class? _____

5. What is your child's least preferred subject/class? _____

6. Has your child ever repeated a grade? ☐ Yes ☐ No If yes, what grade(s)?:_____

7. If your child has been in Special Education, did they have a:

☐ 504 Plan ☐ I.E.P. ☐ Psychological Evaluation ☐ Speech Evaluation
☐ Behavior Intervention Plan ☐ Occupational Therapy Evaluation
☐ Physical Therapy Evaluation ☐ Adaptive Technology Evaluation
☐ Other(s): _____

8. If your child has been in Special Education, how were they served?

☐ Consultation ☐ Resource Classroom ☐ Collaborative Education
☐ Team Taught Classes ☐ Pull-Out ☐ Self-Contained Classroom
☐ Special Program ☐ Psychoeducational Center

9. Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

☐ Football ☐ Karate ☐ Dance (type)_____
☐ Baseball ☐ Piano ☐ Music (type)_____
☐ Cheerleading ☐ Scouts ☐ Gymnastics (type)_____
☐ Basketball ☐ Soccer ☐ Other(s): _____

10. List any special abilities, skills, strengths your child has:

## LEGAL HISTORY

Have you ever filed or been involved in any litigation? Please explain:

## DISCIPLINE INFORMATION

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed:

| Intervention | Very Unlikely=1 Very Likely=2 | Effectiveness | |
|---|---|---|---|
| _____ | Let situation go | ☐ Lease Effective | ☐ Most Effective |
| _____ | Take away a privilege (ex., no TV) | ☐ Lease Effective | ☐ Most Effective |
| _____ | Assign an additional chore | ☐ Lease Effective | ☐ Most Effective |
| _____ | Take away something material | ☐ Lease Effective | ☐ Most Effective |
| _____ | Send to room | ☐ Lease Effective | ☐ Most Effective |
| _____ | Physical punishment | ☐ Lease Effective | ☐ Most Effective |
| _____ | Reason with child | ☐ Lease Effective | ☐ Most Effective |
| _____ | Ground child | ☐ Lease Effective | ☐ Most Effective |
| _____ | Yell at child | ☐ Lease Effective | ☐ Most Effective |
| _____ | Send to time out | ☐ Lease Effective | ☐ Most Effective |

List anything else you may do:

**Go back and check the THREE MOST effective strategies, and the LEAST effective.*

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

Father:_____% Mother:_____% Other:_____% (Please specify):_____

**GENERAL INFORMATION**

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, “I want my child to be more responsible,” translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

| | Like Child to do More Often | Like Child to do Less Often |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

# REINFORCER ASSESSMENT

**Child's Name:**_____ **Date:**_____ **Reporter's Name:**_____

**INSTRUCTIONS: Use a checkmark ( ) to indicate the items or activities preferred.**

## SOCIAL AND SENSORY REINFORCERS

- ☐ Adult attention
- ☐ Attention from specific adults
  List preferred adults:_____
- ☐ Being left alone
- ☐ Time spent with peer
  List preferred peers:_____
- ☐ Freedom from interference from adults
- ☐ Freedom from interference from peers
- ☐ A positive note to give to a person of choice
- ☐ List other_____

- ☐ Hugs
- ☐ OK sign
- ☐ Eye contact
- ☐ Smiles
- ☐ Stim time
- ☐ Jumping
- ☐ Vibrator
- ☐ Motor Lab
- ☐ Sit in adult's lap
- ☐ List other_____

- ☐ Private praise
- ☐ Applause
- ☐ High 5 sign
- ☐ Tickles
- ☐ Being held
- ☐ Swinging
- ☐ Blanket roll
- ☐ Lotion
- ☐ Public recognition

- ☐ Public praise
- ☐ Shake hands
- ☐ Thumbs up
- ☐ Back rub
- ☐ Brushing
- ☐ Twirling
- ☐ Shoes off
- ☐ Powder

## ACTIVITY REINFORCER

- ☐ Music
  List preferred music:_____
- ☐ Playing with toys
  List preferred toys:_____
- ☐ Playing with pets
- ☐ Going for a walk
- ☐ Wearing jewelry
- ☐ List preferred materials:_____
- ☐ Computer programs
  Please list preferred:_____
- ☐ Social activities:
  Please list preferred:_____
- ☐ Leisure activities
  Please list preferred:_____

- ☐ Job responsibilities
- ☐ Wearing cosmetics

- ☐ Puzzles
- ☐ Outside play
- ☐ Riding toys
- ☐ Drawing
- ☐ Cooking
- ☐ More independence
- ☐ Being read to

- ☐ Computer
- ☐ Snack time
- ☐ Books, stories
- ☐ Painting
- ☐ Balloons

- ☐ Water play
- ☐ Free time
- ☐ Painting
- ☐ Visiting
- ☐ Making choices
- ☐ Special seat
- ☐ Bubbles

## AREAS OF INTEREST

- ☐ Animals
  List preferred animals:_____
- ☐ List favorite TV Programs:_____
- ☐ List favorite celebrities:_____
- ☐ List favorite colors:_____
- ☐ Weather
- ☐ Dinosaurs
- ☐ Math
- ☐ Machines
- ☐ Outdoors
- ☐ Trucks
- ☐ Cars
- ☐ Numbers
- ☐ Tools
- ☐ Clothes
- ☐ Trains
- ☐ Science
- ☐ Shapes
- ☐ Sports
- ☐ Computers
- ☐ List favorite movies:_____
- ☐ List favorite songs:_____
- ☐ List favorite places to go:_____
- ☐ Other:_____

_____

**PLEASE LIST THE FOLLOWING:**

Foods disliked_____
Activities disliked_____
Materials disliked_____
Other dislikes_____
Noises disliked_____
Places disliked_____
Animals disliked_____
Known fears_____

## TANGIBLE ITEMS

**PLEASE LIST THE FOLLOWING PREFERRED TANGIBLE ITEMS (by product name/type):**

- ☐ Chips_____
- ☐ Cookies_____
- ☐ Candy_____
- ☐ Fruit_____
- ☐ Cereal_____
- ☐ Other_____
- ☐ Snacks_____
- ☐ Drinks_____
- ☐ Stickers_____
- ☐ Toys_____
- ☐ Games_____

Adapted by the Central Region Autism Spectrum Disorders Team 09/05