COMMUNITY AUTISM SERVICES

THE STEPPING STONES GROUP

WELCOME!

Thank you for choosing Community Autism Services of Georgia for your therapeutic needs.

Our clinic has been thoughtfully planned with your child in mind. The result is a comfortable and nurturing environment where children are inspired to reach their fullest potential. Our state-of-the-art clinic boasts spacious therapy rooms and high-tech observation areas perfect for professional and family collaboration and training. That means families can observe the fun without changing the nature of the therapy session. Family members and caregivers can learn how to incorporate therapy into routines at home, ensuring more consistent carryover,

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GENERAL INFORMATION

Child's Name: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Plan Name_____

Parent/Caregiver Name:	Phone Number	Email
1.		
2.		
3.		

Current Concerns:

_____

_____

_____

_____

Support Coordinator Name_____ Phone Number _____

FAMILY HISTORY

Child lives with:

- □ Birth parents
- □ Adoptive parents
- □ Foster parents
- □ Parent and step parent
- □ One parent
- □ Other:_____

If divorced, is it joint custody? Y N

If joint custody, can we communicate with both parents? Y N

Are we able to communicate with the step-parent? Y N

Other explanation: _____

Other children in the family:

Name	Age	Gender	Speech/Hearing Difficulties/Diagnosis

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Has any immediate or extended family member experienced the following?

- □ Hearing Problems
- □ Learning Problems
- □ Cognitive Delay
- □ Seizure Disorder
- □ Congenital Disorder
- □ Autism
- □ Stuttering

What is the primary language spoken in the home? _____

Please list any additional languages spoken in the home: _____

PREGNANCY Please indicate "Y" for yes and "N" for no.

	Y		N		Bleeding			Y		N	Maternal drug/alcohol use
	Y		N		Excessive weight gain			Y		N	Pre-term labor
	Y		N		Limited weight gain			Y		N	Gestational diabetes
	Y		N		Toxemia			Y		N	Infections
	Y		N		Seizure disorder			Y		N	Multiple birth
	Y		N		Maternal medications (Please list):						

DELIVERY Please indicate "Y" for yes and "N" for no

Y	N	Difficult birth	Y	N	Baby had respiratory distress
Y	N	Prolonged labor	Y	N	Oxygen needed for child
Y	N	Breech birth	Y	N	Cord around baby's neck
Y	N	Brief Labor	Y	N	Cesarean sections
Y	N	Baby treated for jaundice	Y	N	Umbilical cord knot

Other complications: _____

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Were any of the following used during delivery: Epidural Forceps Vacuum suction

Length of pregnancy: _____

Days in the hospital before discharge: _____

Baby's weight: _____

NEWBORN/NURSERY

Please indicate "Y" for yes and "N" for no.

Y	N	NICU stay	Y	N	Hearing screening	Pass Referral
Y	N	Sucking difficulties	Y	N	Brain bleed (if yes, indicate grade level)	
Y	N	Breathing machine			I II III IV	
			Y	N	Was it resolved?	

If "yes" for NICU, how long was the stay: _____

What was the reason for the stay: _____

MEDICAL HISTORY

Please indicate "Y" for yes and "N" for no.

Y	N	Adenoidectomy	Y	N	Lung Problems
Y	N	Asthma/RAD	Y	N	Measles
Y	N	Chronic ear infections	Y	N	Meningitis
Y	N	Cleft Lip/Palate	Y	N	Mumps
Y	N	Depression	Y	N	Pneumonia
Y	N	Ear tubes	Y	N	Scarlet fever
Y	N	Encephalitis	Y	N	Seizures
Y	N	Failure to Thrive	Y	N	Surgeries
Y	N	Head injury	Y	N	Thumb/finger sucking
Y	N	Heart Problems	Y	N	Tonsillitis/Tonsillectomy
Y	N	Anxiety	Y	N	High fevers
Y	N	Allergies(Please list): _____			
Y	N	Other: _____			

Other hospitalizations: _____

Current medications (name, dosage and _____

frequency): _____

_____

Primary Care Physician Name_____ Phone Number_____
Office Address

_____

Adaptive equipment/assisted technology: _____

Y N Do you have any concerns with your child's vision?
Last vision screening date:

Y N Does your child wear glasses?

Y N Do you have any concerns with your child's hearing:
Last hearing screening date:

Y N Do you have any concerns regarding your child's oral health?
Last dental examination:

Y N Are immunizations up to date? If not, please explain: _____

_____

Y N Does your child have a diagnosis? *If so, please list:* _____

Y	N	Allergist	Y	N	Occupational Therapist
Y	N	Cardiologist	Y	N	Pulmonologist
Y	N	Dietician	Y	N	Physical Therapist
Y	N	Gastroenterologist	Y	N	Speech-Language Pathologist
Y	N	Neurologist	Y	N	Other: _____

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DEVELOPMENTAL HISTORY

At what age did your child do the following? Indicate "N" if they have not accomplished it.

Communication	Gross Motor	Fine Motor
• Cooed/babbled ____ • First word ____ • Followed 1-step direction ____ • Used two words together ____	• Head control _____ • Rolled both ways _____ • Sat alone _____ • Crawled _____ • Walked _____ • Jumped _____ • Hopped on 1 foot _____ • Rode bike _____	• Pointed with index finger _____ • Finger fed _____ • Ate with spoon _____ • Cut with scissors _____ • Drew a circle _____ • Removed clothing _____ • Put on clothing _____ • Put on shirt independently _____ • Buttoned independently _____ • Zipped independently _____ • Toilet trained _____ • Combed hair _____ • Bathed independently _____ • Tied shoes _____

EDUCATIONAL HISTORY

Did or does your child attend pre-school? _____

What grade is your child in: _____

What is the name of your child's school? _____

What district is the school in: _____

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Is your child in: General education Resource Self-contained

What is your child's teacher's name: _____

Is it okay to contact the teacher? Y N

Is your child receiving any services in the school? Speech OT PT

Adaptive P.E. Social Work

Any concerns with academic skills? Y N

Any concerns with social skills? Y N

Hand preference? Left Right Difficulty with handwriting? Y N

BEHAVIORAL HISTORY

Behavior Characteristics:

Y	N	Aggressive	Y	N	Plays with others
Y	N	Short Attention	Y	N	Poor eye contact
Y	N	Uncooperative	Y	N	Prefers to play alone
Y	N	Transitioning to (activities, places)	Y	N	Engages is repetitive behaviors
Y	N	Cries, screams often	Y	N	Self-Injurious behavior
Y	N	High activity level	Y	N	Walks on tip toes
Y	N	Impulsive regularly	Y	N	Seeks/avoids movement (circle)
Y	N	Willing to try new things	Y	N	Withdrawn
Y	N	Distracted/avoidant of loud noises	Y	N	Property Destruction
Y	N	Avoids certain textures/temperatures-(Please list): _____			

CURRENT COMMUNICATION

Does your child…

□ Repeat sounds word or phrases over and over?
□ Understand what you are saying?
□ Retrieve/ point to common objects upon request?
□ Follow simple directions?
□ Respond correctly to yes/no questions?
□ Respond correctly to "Wh-" questions?

What does your child currently use to communicate?

□ Joint Attention
□ Sounds (vowels, grunting)
□ Words

□ 2-4 word phrases
□ Sentences
□ Augmentative Communication Device
□ Other?_____

FEEDING DEVELOPMENT

y N Do you have concerns regarding your child's feeding skills? If yes, please explain

_____

_____

Y N Food allergies? If yes, please list:

_____

_____

Please describe the types of food your child eats. (Include type, texture, baby food, table food, etc.)

_____

Where does your child usually eat? (ex: highchair, table, lap):

Y N Any history of difficulty taking the breast/bottle? If yes, please explain:

_____

Y N Any history of reflux or issues associated with feeding? If yes, please explain:

_____

FAMILY CONCERNS AND EXPECTATIONS

What are some of your child's strengths and interests?

_____

_____

What are your concerns about your child?

_____

_____

What do you hope to gain for your child and yourself/family from this program?

_____

_____

Are you interested in information regarding social services? (ex:

Y N psychology/family counseling, grief counseling):

_____

Y N Has your child ever been enrolled in another private therapy program? If yes, please explain:

_____

Agency/Program: _____

City/State: _____

Date Range of Therapy: _____

Services received: _____

THERAPY	# MIN. PER WEEK	CURRENT OR PAST DATE RANGE	APPROXIMATE DATE OF LAST EVALUATION
Speech/Language Therapy			
ABA/Behavior Therapy			
Physical Therapy			
Occupational Therapy			
Psychology/Counseling/SW			
Social Skills Group			

Y N Do you give consent for an evaluation and/or therapies to be provided by Community Autism Services of Georgia?

Y N Do you consent to obtain any evaluations/documentation in person per our standard method of delivery? If not, your evaluation will be mailed to you at the address provided.

Y N Special training is required for the provider

Behavior Treatment Plan Available? Y N Reason for BTP? _____

Method used to gather information _____

Print/ Signature of Parent or Guardian	Date
Print/ Signature of Parent or Guardian	Date
Print/ Signature of Provider	Date
Print/ Signature of Provider	Date

Thank you for choosing Community Autism Services of Georgia to serve your child and family!

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Informed Consent

Child's Name: _____

CONSENT FOR THERAPEUTIC TREATMENT

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at Community Autism Services of Georgia. I understand that I may terminate these services at any time**.**

Signature of Parent or Guardian _____ Date: _____

IF SHARED CUSTODY- Both parties must sign this consent form prior to treatment

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at Community Autism Services of Georgia. I understand that I may terminate these services at any time**.**

Signature of Parent or Guardian _____ Date: _____

CONSENT FOR PARTICIPATION WITH THERAPEUTIC EQUIPMENT

Intervention programs at Community Autism Services of Georgia usually involve the use of specialized equipment such as various swings, bolsters, inflated therapy balls, climbing structures, tactile media (such as soap foam, Play-Doh and lotion), and a variety of other activities that involve fine, gross and oral motor coordination. Therapy activities often involve encouraging the child to try new in order to foster increased skills and abilities. While Community Autism Services of Georgia staff make great efforts to ensure each child's safety, the nature of the therapeutic intervention includes the risk of falling, bumping into other people/equipment. I am aware of the inherent risk of this type of activity, and I give permission for my child to participate in therapy as described.

Signature of Parent or Guardian_____ Date: _____

REVIEW OF RECORDS/RELEASE OF INFORMATION

I consent to communication between Community Autism Services of Georgia and other therapists, teachers, and/or doctors that have previously worked and/or are currently working with my child. I understand that information may be shared with another member of my child's treatment team

outside of Community Autism Services of Georgia, as well as shared with professionals within Community Autism Services of Georgia as part of the treatment process. I understand that the information that is released between the treatment providers is confidential and is for the well -being of my child.

Signature of Parent or Guardian_____ Date: _____

CONSENT FOR VIDEOTAPING & PHOTOGRAPHING FOR THERAPEUTIC PURPOSES

Therapists often videotape or photograph children who receive therapy services at Community Autism Services of Georgia to help monitor and document a child's areas of concern, as well as progress. Videotapes and photos are used and reviewed only by Community Autism Services of Georgia staff. Parents are welcome to view their child's videotape at Community Autism Services of Georgia.

I do____ do not____ give consent for my child to be videotaped and/or photographed as part of his/her therapy program for use by Community Autism Services of Georgia staff only.

Signature of Parent or Guardian _____Date: _____

CONSENT FOR VIDEOTAPING & PHOTOGRAPHING FOR EDUCATIONAL & PUBLIC AWARENESS PURPOSES

Staff at Community Autism Services of Georgia are frequently asked to teach at courses, seminars or workshops. We often like to include videotape, slides or photos during our presentations. Additionally, we may occasionally use photographs to share on Social Media and for promotional purposes.

I do___ do not___ give permission for my child to be videotaped/photographed for educational and public relations purposes. I understand that my child's name and any identifying information, will not be used in association with these images.

Signature of Parent or Guardian _____ Date: _____

Community Autism Services of Georgia Client Policies and Procedures Agreement

☐ **Child Supervision and Staying on Premises**

Caregivers are required to monitor and accompany any children that they are responsible for before, during and after the appointment. This includes habilitation providers, nannies, grandparents and other caregivers involved in your child's life. Our agreement with licensing, insurance carriers and DDD includes a policy that "requires a parent/family member or other caregiver (paid/unpaid) to be present and participate in all therapy sessions in order to:
1. Maximize the benefit of therapy services, including implementing a home program;
2. Improve outcomes; and
3. Adhere to legal liability standards."
Failure to remain on site during your child's therapy session will result in discontinuation of therapy.

☐ **Cancellations/No Shows**

Failure to Notify in Advance: Please notify the **Scheduling Department** within 24 hours' notice via email if you foresee that your child will not be able to attend a session. Your child's therapist has reserved valuable time for your child's treatment. In the event that a therapy session is cancelled with less than 24 hour notice, a fee of $50 will be assessed to the family based on insurance carrier, as DDD is exempt. If there are more than three cancellations with less than 24 hour notice, during a period of three months, a meeting will be scheduled to discuss barriers and possible discontinuation of services.
Contact email: info@ebsctga.com

☐ **Notification of Change in Insurance and Verification of Benefits**

Any changes in insurance policy must be provided to the **Billing Department** within 24 hours via email to ensure proper continuation of coverage. It is your responsibility to cover the costs of any services that are not covered or denied by your insurance. *Division of Developmental Disabilities Division Provider Manual Chapter 37.*
Contact email: info@ebsctga.com

☐ **Modifications to Therapy due to Client Behavior**

Should the quality of your child's appointments be compromised due to your child's dangerous behaviors, aggression to others or self, and/or illness, we reserve the right to discontinue the session(s), temporarily suspend services, and/or refer the child to a more appropriate provider when applicable. Please understand that while our staff that are specifically trained as SLP/OT/PT have minimal behavioral training, they are not fully trained to handle aggressive or self-injurious behaviors.

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☐ **Therapist Absence**

Community Autism Services of Georgia is proud to provide therapists who are highly qualified and effective across all disciplines. In the event of a therapist absence, your child may be seen by a colleague in the same discipline (OT, PT, RBT or ST) for the session. We strive to maintain consistent providers, as the benefits of a solid therapist/child rapport are well known.

☐ **Teaching Facility**

Community Autism Services of Georgia has partnered with our state wide colleges and universities, as well as some out of state colleges in order to prepare future OTs, PTs, RBTs and SLPs in their fields. Student clinicians may observe therapy sessions from the theater or participate in the session with the therapist and child. All students are required to sign Community Autism Services of Georgia confidentiality agreement and adhere to HIPAA and FERPA privacy laws.

☐ **Patient Rights**

I acknowledge that Community Autism Services of Georgia has provided me with a written copy of my patient rights, which are also posted in the front reception area. All clients and/or client representatives are provided with a written copy and informed of the patient rights upon admission to Community Autism Services of Georgia.

Child's Name: _____ **Date of Birth:** _____

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

Signature of Community Autism Services of Georgia Representative:
_____

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Patient Rights (R9-10-1008)

Community Autism Services of Georgia shall ensure that:

1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
    a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
    b. Where patient rights are posted as required in subsection (A)(1).

Community Autism Services of Georgia shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient as not subjected to:
    a. Abuse;
    b. Neglect;
    c. Exploitation;
    d. Coercion;
    e. Manipulation;
    f. Sexual abuse;
    g. Sexual assault;
    h. Except as allowed in R9-10-1012(B), restraint or seclusion;
    i. Retaliation for submitting a complaint to the Department or another entity; or
    j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
3. A patient or the patient's representative:
    a. Except in an emergency, either consents to or refuses treatment;
    b. May refuse or withdraw consent for treatment before treatment is initiated;
    c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
    d. Is informed of the following:
        i. The outpatient treatment center's policy on health care directives, and
        ii. The patient complaint process;
    e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
    f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
        i. Medical record, or
        ii. Financial records.

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A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Unofficial version of the rules in 9 A.A.C. 10, Revised for Perpetual Licensing, effective October 1, 2019

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Patient Rights

1. Be treated with dignity, respect, and consideration
2. Not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse or assault, restraint or seclusion (subject to R9-10-1012(B)), retaliation for submitting a complaint to the Department or another entity, or misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student.
3. Not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
4. Receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities.
5. Receive privacy in treatment and care for personal needs.
6. Review, upon written request, the patient's own medical record.
7. Receive a referral if the outpatient treatment center is not authorized or able to provide certain health services needed by the patient.
8. Participate or have the patient's representative participate in the decisions concerning treatment. Refuse treatment to the extent allowed by law.
9. Receive assistance by the patient's representative or other individual in understanding, protecting, or exercising the patient's rights.

Administrators Shall Ensure That:

10. A patient or the patient's representative either consents to or refuses treatment, except in an emergency.
11. A patient or the patient's representative may refuse or withdraw consent before treatment is initiated.
12. A patient is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure, except in emergencies.
13. A patient or the patient's representative is informed of the outpatient treatment center's policy on health care directives and the patient complaint process.
14. A patient consents to a photograph before taken, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes.
15. A patient provides written consent to release information in the patient's medical record or financial records, except as otherwise permitted by law.

Patient Responsibilities:

16. Providing us with honest, complete information about matters that relate to your care.
17. Showing respect and consideration for the rights of fellow patients, our staff and our property.
18. Complying with the rules of our facility, including our visitor and smoke-free environment policies.

Patient Comment or Complaint Process:

1. Ask to speak with the center's Director of Therapy or Director of Behavioral Services.
2. Any patient or patient's representative has to right to report any concerns to:
   a. Emily Chandler, Clinic Director: emily.chandler@ebsctga.com
   b. Wesley Bennick, Office Manager: wesley.bennick@ebsctga.com

This document contains an unofficial version of the new rules in 9 A.A.C. 10, Article 10, effective October 10, 2019

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PLEASE READ CAREFULLY

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- By signing this form, you understand and agree to send and receive you and/or your family's medical information via in an unencrypted format.
- Free email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email.
- When we send you an email, or you send us an email, the information that is sent is **NOT Encrypted.**
- This means a third party may be able to access the information and read it since it is transmitted over the Internet.
- In addition, once the email is received by you, someone may be able to access your email account and steal sensitive information.
- Email is a very popular and convenient way to communicate, however it is not safe.
- The HIPAA act requires we provide options for receiving protecting health information.
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website at http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email and that same patient provides consent to receive health information via email, then a health entity may send the patient personal medical information via unencrypted email.

MEDICAL RELEASE OF INFORMATION - ALLOW UNENCRYPTED EMAIL CORRESPONDENCE

I understand the risks of unencrypted email and do hereby give permission to Com munity Autism Services of Georgia to send and receive all personal health information, reported, documents, and evaluations via unencrypted email. I release Community Autism Services of Georgia from any further liability from the release of all Protected Health Information.

Signature: _____

Date: _____

Printed Name: _____

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Please print email address you would like to use for all future correspondences (parent or guardian if patient is a minor).

Email Address: _____

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Community Autism Services of Georgia Health Policy

For the safety of your child, parents/guardians of children with Allergies, Asthma, or Seizures must remain present either in the therapy room or the waiting area during the entire therapy session. If a seizure, asthma attack, or allergic reaction occurs during a therapy session, the therapist will need to end the session.

Allergy

Allergy: Yes/No
Allergic to: _____
Please describe reaction:
_____
Medications given:
_____

If you circled **yes**, please complete the following Emergency Protocol form. If you do **not** feel a plan is necessary at this time, please sign the statement below.

I do **not** feel my child needs an allergy plan at this time.

Signature: _____ Date: _____

Seizure

Seizures: Yes/No
Frequency:
_____
Please describe:
_____
Medications given: _____

If you circled **yes**, please complete the following Emergency Protocol form. If you do **not** feel a plan is necessary at this time, please sign the statement below.

I do **not** feel my child needs a seizure plan at this time.

Signature: _____ Date: _____

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Asthma

Asthma: Yes/No
Known Triggers: _____
Frequency:
_____
Medications given:
_____

If you circled **yes**, please complete the following Emergency Protocol form. If you do **not** feel a plan is necessary at this time, please sign the statement below.

I do **not** feel my child needs an asthma plan at this time.

Signature: _____ Date: _____

Community Autism Services of Georgia will do its part to work with families of children with medical needs to ensure safety during our therapy sessions. By signing below, you agree that you have disclosed any known history of allergies, asthma, or seizures and will work with our staff to create a plan to address these concerns as needed.

Parent Signature: _____ Date: _____

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Emergency Protocol

Child's Name: _____ Date of Birth: _____

Date of Plan: _____

Medical Condition	Causes/Triggers
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Parent/Guardian Name: _____

Home: _____

Mobile: _____

Work: _____

Physician Name: _____

Telephone: _____

Emergency Contact:

Name: _____

Phone: _____

Relationship to Child: _____

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Briefly describe your child's medical condition and symptoms:

_____

_____

_____

If Child Displays the Following Symptoms:	**Take the Following Actions:**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

Community Autism Services of Georgia staff will do its part to be continually aware of your child's specific allergies. Unfortunately, it is not possible to prevent all accidental exposures at our center. By signing below, you understand and acknowledge that Community Autism Services of Georgia will not be held liable for any future allergic reactions or exposures that a child may have in our clinic.

Before serving your child, Community Autism Services of Georgia will need a copy of your child's Emergency Protocol. All emergency plans, including medication (i.e., EpiPen, inhaler, etc.) administration, require parent/caregiver/guardian to stay on the premises throughout the duration of their therapy sessions to administer the Allergy Protocol.

Signature: _____ Date: _____

Relationship to Patient: _____ Date: _____

Therapist Signature: _____ Date: _____

Clinical Director Signature: _____ Date: _____

Community Autism Services of Georgia
4319 South Lee Street, Suite 300, Buford, GA 30518 Phone: 678-288-9770

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____	_____	___	____/____/____
Patient's Last Name	First Name	MI	Date of Birth

_____	_____	_____	_____
Phone #	Street Address	City and State	ZIP

Please specify the health information that you are authorizing for release:

Dates of Service Covered by this Release: ____/____/____ to ____/____/____

Types of Records covered by this Release:

- ☐ All Medical Records
- ☐ Speech Therapy/Diagnostic Information
- ☐ Physical Therapy/Diagnostic Information
- ☐ Occupational Therapy/Diagnostic Information
- ☐ Psychological/Neuropsychological Diagnostic Information
- ☐ Mental Health Therapy/Diagnostic Information
- ☐ Progress Notes

Purpose of Release (*REQUIRED*):

☐ Coordination of Care ☐ Insurance ☐ Legal ☐ Personal Reasons

☐ Other: _____

Release the information between the following entities:

Community Autism Services of Georgia
4319 South Lee Street, Suite 300
Buford, GA 30518

Name: _____

Address: _____
_____

RECIPROCITY OF RELEASE: It is my desire that the medical information be shared between both parties listed above. I authorize Community Autism Services of Georgia and _____ to mutually share medical treatment information on an ongoing collaborative basis via written or verbal exchanges.

I hereby authorize Community Autism Services of Georgia to release to the requestor and/or obtain the medical record(s) checked above, including those which may contain confidential HIV/AIDS-related information, confidential communicable disease related information, and/or information relating to mental health and/or drug/alcohol abuse.

While Community Autism Services of Georgia makes every effort to protect the privacy of your medical information, please note that release of your medical information to the authorized person or organization could be the subject of re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA") or other federal or state laws. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken by notifying Community Autism Services of Georgia in writing. I will allow the information to be faxed if necessary. This authorization will expire within 90 days unless you specify otherwise.

_____	_____	___/___/___
Signature of Requestor	Relationship to Patient	Date

_____	___/___/___
Signature of Parent/Guardian (minors aged 0-17)	Date

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Telephone: 678.288.9770 • Fax: 678.288.9774 • Email: info@ebsctga.com

Patient Intake and Financial Form

Patient Name: _____ DOB: _____

Home Address: _____

_____

Home Phone: _____ Cell Phone: _____

E-mail address: _____

Mother's Name: _____ DOB: _____

Father's Name: _____ DOB: _____

Pediatrician/Doctor:

_____

Clinic Name:

_____

Phone: _____ Fax: _____

Child's Diagnosis (if known) and Year:

_____

Reason for Referral:

_____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Mailing Address for claims:_____-

_____

Subscriber's Name: _____Subscriber's DOB: _____

Policy ID #: _____Group #: _____

Employer/Group Name:_____

Katy Beckitt Waiver: □ Yes □ No

Medicaid: □ Yes □ No □ Peachstate

Medicaid #: _____

My signature indicates that, to the best of my knowledge, all information provided above is accurate and current. I understand if additional service time is requested on my part above what is recommended, I agree to pay the current private pay rate for any additional service time. I understand that if my insurance or Medicaid information changes at any time, it is my responsibility to notify *Community Autism Services of Georgia* of the noted changes. Failure to do so will result in my responsibility for payment of services if insurance/Medicaid denies services due to lack of authorization and/or verification of benefits.

Signature: _____ Date: _____

_____

Name of Person Completing This Form

_____

Relationship to Patient

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THE STEPPING STONES GROUP

Cancellation, Illness, HIPAA and Insurance Change Policy

Consistency is vital to the therapy process. Your therapist's plan can only be effective when attendance is regular and consistent with the scheduled therapy time. Please review the guidelines below regarding the cancellation and tardiness procedures:

Late Arrival: Please call the clinic to notify you will be running late to your appointment. Failure to notify will result in a No-Show and total session cancellation after 15 minutes. If you *have* notified the clinic and are 15 minutes late, your session end time will remain the same. If there are three late arrivals within a one month period, a meeting will be scheduled to discuss barriers and possible discontinuation of services. *Late fees and late cancellation fees must be paid prior the child's next session at the clinic.*

Vacation: Please inform the Scheduling Department via email of upcoming absences due to vacation with at least two-week notice. Your therapy session appointment times are not guaranteed to remain at the same after two weeks of suspended service for vacation.
Contact email: info@ebsctga.com

Illness: Please call the clinic and email the Scheduling Department as soon as you know that your child may miss your scheduled session due to illness. Please see below for extended Illness Policy.
Contact email: info@ebsctga.com

Doctor Appointments/Other: Routine Dr.'s visits, meetings and other flexible appointments should be scheduled so they do *not conflict* with *the existing therapy appointment*. Therapy is a medical necessity for your child's development, and should be treated as such.

Inconsistent Attendance: In the event that your family becomes unable to attend sessions regularly, we will make every effort to accommodate your family's needs. Excessive illness will be taken into consideration for continuation of therapy.

Initials: _____

COMMUNITY AUTISM SERVICES
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Illness Policy

While attendance is vital, it is also important to protect your child, as well as the health of the therapists and other children. Please understand that a child must be in good health to have a successful and productive therapy session. We require children to be symptom and fever-free for at least 24 hours prior to returning for a session. If a child is on an antibiotic for an illness, the medication must be administered for at least 24 hours before returning to the clinic. Please contact the clinic as soon as you know that your child may miss your scheduled session due to illness.

The following circumstances warrant cancellation (with possible rescheduling) of the therapy session:

- Child is unusually lethargic or irritable
- Presence of yellow or green mucous secretion
- Vomiting/diarrhea
- Fever (within 24 hours of session)
- Seizures
- Open skin sores
- Rash or hives
- Head lice or nits present
- Pink eye
- Explained rash
- Strep throat
- Chickenpox
- Ringworm (must be 24-48 hours on treatment and completely covered if rash is still present)

Initials: _____

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HIPAA Notification Policy

Please review our Notice of Privacy Practices carefully.

The privacy of your health information is important to us. This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this HIPAA Notification Policy about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described. This policy takes effect (09/01/2003) and will remain so until further notice.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Policy at any time. For more information about our privacy practices or for additional copies, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We may use and disclose health information about your child for treatment, payment, and healthcare operations.

Possible examples of how your personal health information may be utilized is as follows:
Treatment: We may use or disclose your health information to a physician or other healthcare provider who is providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: If we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes, we may disclose your health information to appropriate authorities.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as e-mail and voicemail messages, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this policy. We will charge you a reasonable cost-based fee for expenses such as copies, and staff time. You may also request access by sending us a letter to the address at the end of this policy. If you request copies, we will charge you $.35 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years,

but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions, please contact us.

Araceli Campa-Reyes
4319 South Lee Street, Suite 300
Buford, GA 30518
Phone: 678-288-9770
Email: araceli.campa-reyes@ssg-healthcare.com

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

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We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us, the GA Department of Health Services, or with the U.S. Department of Health and Human Services.

Initials: _____

Notification of Insurance Changes/ Renewal Policy

Community Autism Services of Georgia must have CURRENT information on file regarding insurance at all times. It is the responsibility of the parent/ guardian to know of any and all changes in your insurance policy. It is also the responsibility of the parent/ guardian to notify Community Autism Services of Georgia of any changes in the insurance policy within 24 hours.

DDD Policy Holders: Insurance verification is based upon information provided to your support coordinator during your initial meetings and at any time of a change. Once therapy begins, it is our responsibility to first attempt to collect from your insurance. If insurance does not over the therapy provided we then bill DDD and accept the contracted rate as full payment. **It is not the responsibility of Community Autism Services of Georgia to learn of changes in your insurance status at any time following the initial authorization process with DDD.** Failing to report changes of insurance to DDD results in our inability to be compensated for the therapy services provided.

Private Insurance Policy Holders: As a courtesy, we will call to verify benefits and will make reasonable effort to collect from your insurance company. Primary responsibility for understanding coverage limits belongs to the parent. There are instances when insurance may deny benefits (deductibles not met, services not covered under the plan, etc.) and you will be responsible for the payment. Any payment that is due from the parent following an insurance denial is due at the time of service.

AHCCCS Policy Holders: We will request authorizations for therapy services and provide necessary documentation to your policy for ongoing treatment as needed. In the event you have changed your plan, the billing specialist must be notified. There are many

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AHCCCS plans to choose from and they are all different. We must have the current plan on file.

ANY CHANGES IN INSURANCE POLICY MUST BE REPORTED TO THE BILLING SPECIALISTS

We thank you in advance for your cooperation.

I have *received a copy* and agree to abide by the terms of Community Autism Services of Georgia
(effective August 2019):

- **Cancellation/Late Arrival Policy**
- **Illness Policy**
- **HIPAA Notification Policy**
- **Insurance Changes and Renewal Policy**

I acknowledge that I have received the Notice of Privacy Practices (Notice). The Notice describes, in accordance with the HIPAA Privacy Regulations, how Community Autism Services of Georgia may use and disclose my child's protected health information to carry out treatment, payment or health care operations and for the other specific purposes that are permitted or required by law. The Notice also describes my rights and Community Autism Services of Georgia's duties with respect to protected health information about my child.

_____

Child's Name

_____ _____

Signature of Parent or Guardian Date

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Section A: To the Patient – *Please read the following statements carefully*.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out Treatment, Payment activities, and healthcare Operations (TPO).

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

With my permission the office of ***Community Autism Services of Georgia*** may call my home or other designated location and leave messages on voice mail that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my permission the office of ***Community Autism Services of Georgia*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient invoices and statements.

With my permission, the office of ***Community Autism Services of Georgia*** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder and patient invoices and statements.

I have the right to request that ***Community Autism Services of Georgia*** restrict how it uses or discloses my protected health information to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

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You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Director of Therapy
Email: emily.chandler@ebsctga.com

Section B: Parent or Guardian Giving Consent (if Patient is not 18 years of age and their own guardian

Name: _____Date: _____

Relationship to Patient: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice of your revocation submitted to ***Community Autism Services of Georgia attn.: Emily Chandler, Clinic Director.*** Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may *decline* to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date: _____