BECKHOM BEHAVIORAL CONSULTING, LLC

Mailing Address: P.O. Box 51293 ✧ Albany, Georgia 31703
Clinic: 1509 West Third Ave. Albany, GA 31707
Phone (229) 439-9951 ♦ Fax (229) 439-9553
Email: info@beckhombehaviorconsulting.com
Website: www.beckhombehaviorconsulting.com

Welcome to Our Practice!

Thank you for choosing Beckhom Behavioral Consulting to help you meet the needs of your loved one and family. We realize that you had many options to choose from, and appreciate your having selected our practice to assist you with this important process.

The attached packet contains information that we will require to provide you with the most accurate and complete assessment. All of the following forms, reports, and documentation must be received prior to your first appointment. We understand that some of these forms may be time consuming and in some places redundant. However, the more information that we can acquire, the better we are able to assist you and your family. Please assure that all forms and requested information is available on the day of your scheduled appointment.

Please contact our office at (229) 439-9951 should you have any questions, concerns, or need to reschedule your appointment.

We look forward to working with you and your child.

Sincerely,
Katrina Wilburn-Beckhom, M.S., BCBA
Program Director

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The attached packet includes important information about our practice, including fees, payment policies, privacy policies and client rights. Please take time to review all of the information carefully. A client intake form and consent form are also included and must be completed and returned prior to your first appointment. Please attach any additionally requested information.

Included For Completion:

- ❒ Psychosocial Assessment (Intake Forms)
- ❒ Client Confidentiality Form
- ❒ Authorization to Exchange Information Form
- ❒ Photograph Consent Form
- ❒ Payment Contract
- ❒ Consent For Treatment
- ❒ Receipt of Policies and Procedures, Client's Rights, and Notice of Privacy Policies

Provide the following Additional Documents

- ❒ Copy of most recent IEP/IFSP (include Behavior Intervention Plan BIP-if applicable)
- ❒ Copy of most recent comprehensive evaluation (i.e., psychological, behavioral, etc.)
- ❒ Copy of report indicating a Diagnosis of Autism (Diagnostic codes (299.0; 299.8) by a licensed practitioner (not school report) (if seeking insurance funding)
- ❒ A prescription for ABA services by a physician
- ❒ Copy of most recent speech/occupational therapist evaluations and goals
- ❒ Copy of Relevant medical reports
- ❒ Copy of front and back of current insurance card

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Email: autism-behaviorconsulting@hotmail.com
Website: www.beckhombehaviorconsulting.com

Psychosocial Assessment (Intake Forms)

Client Information	Today's Date:
Last Name:	Age: yrs months
First Name:	Date of Birth:
Middle Name:	Gender:
Nickname:	Race:
Home Phone:	Lives With:
Address:	County:
City: State:	Zip Code: Country

Primary Diagnosis:	Age at Diagnosis:
Secondary Diagnosis:	Age at Diagnosis:
Other Diagnosis:	Age at Diagnosis:
Other medical Conditions:	
Allergies:	

Dietary Restrictions: ☐ Yes ☐ No	Explain:
Gastrointestinal problems ☐ Yes ☐ No	Explain:
Stereotypical Behaviors ☐ Yes ☐ No	Explain:

Mother or Legal Guardian Information	
Full Name:	Relationship to Client:
Address:	Marital Status:
City:	Occupation:
State: Zip:	Business Phone:
Home Phone:	Best Time to Contact:
Cell Phone:	Email:
Fax:	Primary Language Spoken:

Father or Legal Guardian Information	
Full Name:	Relationship to Client:
Address:	Marital Status:
City:	Occupation:
State: Zip:	Business Phone:
Home Phone:	Best Time to Contact:
Cell Phone:	Email:
Fax:	Primary Language Spoken:

Applicant's Siblings:		
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

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Family History:

Is there a family history of any learning difficulties, attention difficulties, psychological disorders, developmental delay, and/or substance abuse problems?	☐ Yes ☐ No If yes, please explain.

Medical Information

Is the individual on medication? ☐ Yes ☐ No

If yes, list medication, administration times, usage:

Type of Medication	Dosage	Administration Times	Used for

Additional medications can be attached on a separate sheet of paper and stapled to this application

Are there medical conditions that would interfere with ABA therapy? ☐ Yes ☐ No If yes, please explain.

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History of Treatment	
❒ **Behavior Consultation Provider**	Dates of service: _______ to _______
Provider Agency:	
Provider Name:	
Provider Phone:	
Frequency of provider consultation:	
Methods of treatment by the provider. ☐ ABA Therapy ☐ Greenspan/ Floor time ☐ Mental Health Counseling	☐ Early Intervention Services ☐ Life Skills Training, Vocational, Job Coach, etc ☐ Other
Please describe services by the provider and program information. Describe results of treatment goals.	

Present School/Community Placement	
Name of School or Current Placement:	**Years attended:**
Address:	**Placement:**
City: State: Zip:	**Phone:**
Teachers/Staff:	
Please describe primary goals and progress:	

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Supportive Services

What other services is the individual <u>currently</u> receiving? Please enclose a copy of the IEP, IFSP, ISP, and Therapy goals from each area that is checked.

Service/Therapy	Location	Minutes/Week
☐ Early Intervention Services	☐ School ☐ Home	
☐ Speech and/or language therapy	☐ School ☐ Home	
☐ Occupational and/or Physical Therapy	☐ School ☐ Home	
☐ Vision services in school	☐ School ☐ Home	
☐ Hearing services	☐ School ☐ Home	
☐ Adult Services	☐ School ☐ Home	
☐ Other	☐ School ☐ Home	

Please describe the results of these therapies in regards to success in achieving goals.

Functional Skills: Describe the level of assistance the individual requires to complete daily task. Ex., Independently toilets self, needs physical assistance to get dressed, cannot tie shoes at all, needs help brushing teeth, bathing, grooming, requires 24/7 supervision, etc.

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Problem Behavior: What, if any, behavioral challenges do the individual exhibit? Ex., self-injurious, aggressive towards others, destroys materials, runs away etc. Please explain. Include methods used to decrease these behaviors.

Communication Skills: What current communication skills does the individual have? Ex., gestures, pulls on adult, sign language, PECS, one word utterances, complete sentences, echolalia, etc. Please explain.

Social/Play Skills: Describe the individual's social or play skills. Ex., interacts well with others, play alone, plays with others, interacts with same age peers, has no friends, etc. Please explain. Include methods used to improve these behaviors.

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Talents/Hobbies/Strengths: List any special abilities, skills, strengths, the individual has:

Reinforcers: Please list interests (food, magazines, toys, leisure activities, etc.)

What else would you like us to know about the individual who needs services?

What are your immediate goals for the individual?

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What level of involvement/commitment are you willing to make at home in order to achieve these goals?

What hours is the individual available for therapy? (generally between 8:30-5:30pm)
Monday
Tuesday
Wednesday
Thursday
Friday

The undersigned hereby acknowledge that the information contained in this application is accurate in all respects.

Parent/Guardian (print name) ____ **Date:** ______________

Parent/Guardian (print name) ____ **Date:** ______________

Signature of PARENT/GUARDIAN: _________________________________ **Date:** _______________

Signature of PARENT/GUARDIAN: _________________________________ **Date:** _______________

**Please send completed forms and supporting documents to:*

Beckhom Behavioral Consulting, LLC
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Email: autism-behaviorconsulting@hotmail.com
Website: www.beckhombehaviorconsulting.com

Client Name: ______________________ DOB: ____________________

Client Confidentiality

Client confidentiality is a top priority at Beckhom Behavioral Consulting, LLC. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.

In the event that I, ____________________________, am unable to be reached, Beckhom Behavioral Consulting may leave information with the following:

_____ Other Adult in Household (Name): ______________________________

_____ On home Answering Machine (#): _______________________________

_____ On Cell Phone (#): ___________________________

_____ I may be reached at my work number: __________________________

_____ May leave a message at work on my voicemail: _____________________

_____ Other (Please specify): ____

_______ (Initials) In the event that I am unable to be reached, Beckhom Behavioral Consulting **May Not** leave information with anyone but myself**.**

I understand that if the status of any of this information changes, it will be my responsibility to inform the staff at Beckhom Behavioral Consulting.

Individual's Signature: _________________________________ **Date:** ____________

Parent/Guardian's Signature: _________________________________ **Date:** ____________

Parent/Guardian's Signature: _________________________________ **Date:** ____________

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AUTHORIZATION TO EXCHANGE INFORMATION

I, ____, do hereby authorize: Beckhom Behavioral Consulting, LLC, including all employees, to exchange information from the record of
____ DOB __________________________.
(Print Client Name)

The information that may be released/obtained/discussed includes:

☐Physical Examination
☐Birth Record
☐Medical Examination
☐Psychological Examination
☐Psychosocial History
☐IEP/IFSP
☐Progress Notes
☐Summary of Treatment to Date
☐Discharge Summary
☐After Care Plan
☐Medication Record
☐Education Record

I understand that Beckhom Behavioral Consulting, LLC will keep information and documentation confidential. I understand that this consent to release information is valid for the period of time in which the above named person is an active client.

I understand that I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose(s) specified above.

I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon), by written, dated, communication to the Director of Beckhom Behavioral Consulting, LLC.

____ _________________________
Signature of Parent/Guardian Date

____ _________________________
Signature of Parent/Guardian Date

(   ) I have chosen to receive a copy of this Release
(   ) I have chosen not to receive a copy of this Release

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Consent To Use Audio/Visual Images

By marking the yes box of this form, I give Beckhom Behavioral Consulting, LLC (BBC) consent to have photographs, videotaped images, or other recordings, either audio or visual, made of my child(ren) during the course of therapy. I understand and agree that these images may be used by BBC for a variety of purposes, including evaluation and assessment, training, presentations, research, use on website, print, and/or other BBC media material. However, no audio recordings or visual images will be captured without the knowledge of parent(s).

Consent to capture and use still and moving images of your child(ren) is optional. However, the frequency of direct observation by supervising BCBA(s) may be substantially inhibited when they can only be accomplished on-site. This may adversely affect the supervision/support schedule.

❒ Yes, I have read, understand, and agree with the provisions of the consent to use audio/visual images; and I agree that the above images are the sole property of Beckhom Behavioral Consulting, LLC.

❒ Yes, I have read, understand, and agree with the provisions of the consent to use audio/visual images; and I agree that the above images are the sole property of Beckhom Behavioral Consulting, LLC. HOWEVER, I CONSENT ONLY TO THE USE OF THESE IMAGES FOR SUPERVISION, EVALUATION AND ASSESSMENT PURPOSES.

❒ No, I DO NOT give my consent to BBC, LLC to use audio/visual images of my child(ren) or adult client.

______________________	____________	______________________
Parent's Signature	Date	Individual's Name
______________________	____________	______________________
Parent's Signature	Date	Individual's Name

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PAYMENT CONTRACT

Careful consideration has been taken in establishing our fees. We assure you that our charges reflect the time, quality, and level of expertise that is required to render you a high standard of services. Our fees are well within the range of fees generally accepted in the field of behavior analysis for services. Fees and arrangement for payment of services will be discussed with you either before or on your first visit.

The person who signs the *Payment Contract* is responsible for payment of all services rendered. In most cases, payment is due at the time services are rendered unless you have made other arrangements with us in advance. Some ongoing services (such as ABA therapy) may be invoiced monthly for your convenience. Payment is due immediately upon receipt of the invoice. There is a **5% monthly discount for establishing automatic monthly credit or debit card payments**. Authorization can be established by completing the Recurring Payment Form from our office. Accounts more than 30 days overdue or exceed $1,500.00 will be subject to a 5% penalty. A 5% penalty will accrue monthly thereafter on all accounts that remain past due. Services may also be suspended. Checks returned by the bank will result in an additional charge of $40. Accounts more than 60 days overdue will be sent to collection. **For clients seeking third-party reimbursement please be aware that the financial obligation for our services is between you and this office, and NOT between us and the insurance company or other agency. You are ultimately responsible for the payment of services rendered.** Beckhom Behavioral Consulting accepts cash, check, Visa, or MasterCard. Payments may be made online via Paypal.

There are very few insurance carriers in Georgia that reimburse for ABA services at this time. However, with the passing of AVA's Law we expect this situation to change soon. We will work with insurance companies as reimbursement services become available. We will inform families of our in-network status with insurance carriers as these partnerships are established. For out-of-network services we will have to contact the insurance carrier to determine if we can partner with them to provide services for your child. A copy of your driver's license and front and back of your insurance card is required before services begin. Benefits will be verified upon receipt of your information and you will be made aware of any **estimated** out-of-pocket expenses before services are started or following any changes in your insurance. Authorization must be determined before services begin. Information obtained from insurance companies is not always a guarantee of payment. **Families are ultimately responsible for payment of services rendered**. Families will need to assign benefits for filed claims to be paid to Beckhom Behavioral Consulting. Any payment sent directly to the family intended to cover services provided by Beckhom Behavioral Consulting, should be submitted to our office. **Families are responsible for all co-pays, coinsurance, and deductibles associated with services**. The insurance billing rate is higher than your out-of-pocket rate to account for the administrative fees associated with insurance billing.

For carriers that will not authorize services, or whom do not have out-of-network services, the client/responsible party must pay fees upfront. We will provide a coded invoice to clients who may choose to seek reimbursement from their insurance carrier independently. If the client is receiving funding from an outside funding source or agency and has proper documentation/verification, Beckhom Behavioral Consulting will bill the outside funding source/agency for services rather than the family. In the event that the outside agency does not approve the claim for payment, the client/responsible party must pay for services. Fees may be adjusted at any time without prior notice. Please contact our billing manager if you do not have insurance coverage or are experiencing financial hardship.

We understand that emergencies and illness arise which may cause a session to be cancelled. There are no fees associated with occasional cancellations, provided the therapists or Senior Clinician is notified by phone at least 12 hours prior to the scheduled appointment. If notification is not made at least 12 hours in advance, there is a no call/no show, or cancellations happen frequently (e.g., more than 15% of sessions), an hour of the therapist's or Senior Consultant's time will be billed for the scheduled session. In addition if you arrive late to a scheduled appointment, you will also be billed the rate of the full appointment. Repeated failure to attend scheduled sessions may result in termination of services. Insurance carriers are not responsible for missed appointment fees.

The client/responsible party agrees not to recruit and hire staff involved in the delivery of services provided by Beckhom Behavioral Consulting for a period of 1 year following the termination of this contract.

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Invoicing:
Invoices are mailed or emailed once per month for services provided during the previous month and are generally mailed prior to the 15th of each month. For example, an invoice for all October services would typically be mailed by the 15th of November.

Termination of Services:
BBC consultants and/or therapists are reimbursed regularly and timely regardless of individual account statuses. When accounts fall unreasonably behind, this becomes difficult to sustain. Consequently, services are subject to discontinuation if payments on unpaid portions of account balance fall more than 60 days delinquent.

PhD: BCBA-D: $150/hr
Masters: BCBA: $125/hr
Masters Level Consultant: $90/hr
Registered Behavior Therapists: $65/hr

Mileage Fees: For clients residing outside the Albany area, mileage is billed at the current IRS rate for each provider who renders services and for each in-person service that is rendered (e.g., direct testing for evaluations, team meetings, direct therapy services). Mileage will be assessed on a round-trip basis and calculated from the BBC office at 1509 West 3rd Avenue, Georgia 31707.

I have read and understand Version 2.1 updates and agree with terms including that I am responsible for the payment of all charges incurred regardless of any insurance coverage or other plans available to me. Additionally, I understand and agree to pay any and all collections costs and/or attorney's fees if any delinquent balance is placed with an agency or attorney for collection, suit, or legal action. I also acknowledge that confidentiality is waived in matters involving collections and the sharing of information sufficient to pursue recovery of debts owed.

PARTY RESPONSIBLE FOR PAYMENT

This contract shall remain effective for the duration of time that the client is actively receiving services from Beckhom Behavior Consulting or its affiliated companies. Continued receipt of services after updates to this contract have been received will be considered indication of agreement with this contract until the responsible party signs and returns the contract.

Signature: ___________________________________ Date: __________________

SSN: _________________________ DL#: _______________________ State _________

Note: Party Responsible for payment must have signed or be present at initial appointment to sign Payment Contract. If this is not possible, please contact our office prior to the appointment to make other arrangements.

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Beckhom Behavioral Consulting Service Model

Prior to or during the initial assessment, it will be discussed if services will be conducted using one of two models, Direct Therapy or Consultation.

In the Direct Therapy service model, a schedule of therapy sessions is set up according to the availability of the family and staff for a number of hours agreed upon by the family and Beckhom Behavioral Consulting at the time of assessment. Depending on the number of hours per week multiple staff members may be required to meet the service need. All staff will be trained in the programs the same and will be supervised to ensure consistency with protocol. The use of multiple staff may also lead to program generalization and allow for easier coverage should staff absence occur.

A Senior Clinician or Supervising Consultant will be assigned to the case (Usually a Board Certified Behavior Analyst or Master's level consultant). It is the Senior Clinician's/Consultant's duty to write and monitor all programs and make certain they yield the desired results. They also provide parent training and ongoing support, analyze data, and write reports and annual re-evaluations. Staff training will be ongoing and new staff may observe sessions as part of the training process. This is not billed to the family. We require the Senior Clinician or Supervising Consultant to provide program development in the office for the direct therapy model. As an estimate, a program receiving 0-6 hours of direct therapy a week may get one hour of program development per week. A program receiving 7-12 hours of direct therapy a week may get two hours and so on. The family will be billed for this time at the Clinician's/Consultant's hourly rate. This is a requirement of our program. It is essential to ensure the quality of our program.

In the Consultant model, a Senior Clinician or Supervising Consultant is assigned to the case. They will set up an individualized treatment plan addressing the areas of improvement agreed upon in the initial assessment. They will then train the family, teachers, or any other caregivers on the treatment plan and consult on an as-needed basis to monitor the results, making changes as they arise. Should the family hire student aids to provide direct therapy hours, the Consultant may provide training and supervise their work on the case.

** Although we do our best to provide consistency in the therapist performing the services, we cannot guarantee that staff changes will not occur. Changes may need to be made to the schedule from time to time. We will give the family as much notice as possible and discuss these changes before they occur. The cost associated with each service level is listed below. There are additional costs associated with medical billing.

PhD BCBA-D: $150/hr
Masters: BCBA: $125/hr
Masters Level Consultant: $90/hr
Registered Behavior Therapists: $65/hr

Mileage Fees: For clients residing outside the Albany area, mileage is billed at the current IRS rate for each provider who renders services and for each in-person service that is rendered (e.g., direct testing for evaluations, team meetings, direct therapy services). Mileage will be assessed on a round-trip basis and calculated from the BBC office at 1509 West 3rd Avenue, Georgia 31707.

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POLICIES AND PROCEDURES

Cancellation/Scheduling Policy
Appointments
Employees are expected to limit cancellations and to be respectful of families' time and plans. This includes advance notice when emergencies, sickness, childcare issues, and other inevitable interfering events occur.
Likewise, we ask that parents be respectful of the time of BBC personnel; this includes minimizing cancellations and late arrivals.

Cancellations/No call-No show: There are no fees associated with occasional cancellations, provided the therapist or Senior Clinician is notified by phone at least 12 hours prior to the scheduled appointment. **If a session is cancelled with less than 12 hours notice, there is a no-call-no-show or cancellations happen frequently (e.g., more than 15% of sessions), an hour of the therapist's or Senior Consultant's time will be billed for the scheduled appointment.**

Late arrivals: Therapists/Consultants may decide at his/her discretion if they will see a client who arrives later than 15 minutes. If he/she decides to proceed, the session will end at the scheduled time, unless the therapists/consultant was late. Scheduled appointments will be billed from the time the appointment was scheduled to begin, or (b) the time the therapist and or Senior Clinician/Consultant arrive(s) whichever occurs later.
BBC employees are expected to be prompt and dependable. Please contact your Program Director or Clinical Supervisor should you feel that this is not the case.

Leaving during in-home sessions: Parents and/or guardians are welcome to observe therapy, so as to follow through on treatment implementation, but there is no requirement related to the frequency and/or duration of those observations. However, AT LEAST ONE PARENT OR GUARDIAN MUST BE AVAILABLE ON THE PREMISES AT ALL TIMES DURING EVERY THERAPY SESSION.

In-clinic Observations: Must be scheduled and approved by the Program Director or Clinical Supervisor in advance.

Please cancel sessions in accordance with typical public school sickness policies. Below is a list of symptoms, though not necessarily comprehensive, for which students would generally be withheld from school. Accordingly, students should not usually participate in therapy sessions when these symptoms are present.

Client Sickness Policy
Beckhom Behavioral Consulting will not work with individuals if they are running a fever, have an infection, or are thought to have any contagious illness. Likewise, we will not knowingly permit a sick or contagious therapist to work with your child or family. Some symptoms that warrant cancellation are listed below.

Diarrhea - Three or more watery stools in 24-hour period
Vomiting- Vomiting two or more times within the past 24 hours
Rash- Body rash, especially with fever or itching
Sore throat- Particularly if accompanied by fever and/or swollen glands in the neck
Lice/scabies- Students should not participate in therapy until they are free of lice or nits
Fever- Temperature of 100 degrees F (orally) or higher
Cough- Lasting more than one week
Pinkeye- Teary, redness of eyelid lining, irritation followed by swelling and yellow draining
Nasal discharge Greenish, lasting more than one week

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Vacations
Any extended vacations (over 2 missed sessions) need to be notified in writing to BBC at least four weeks prior to date of departure. Shorter vacations (1 missed day) need to be communicated at least 1 week prior to the missed day. When staff schedule planned vacations or personal days, we ask that they inform the family as soon as possible. The staff will attempt to either reschedule the appointment/s or find coverage.

In-home Services
Parents, guardian or adult responsible for supervising the child is expected to remain in the home during the session and should make sure that necessary material and reinforcers are available for the child's services.

If the therapist has a break between sessions, the parent(s) or responsible adult must be available to receive the child.

Parents must give ample notice when shortening sessions, and must be familiar with and follow policies when cancelling sessions due to child illness.

Parents are responsible for personal care of their child during sessions, unless specifically outlined.

Confidentiality
Your privacy is very important to us. We strongly recommend that you review our Notice of Privacy Policy for important details regarding our policies for maintaining confidentiality. In particular, you should be aware that we will only contact you via means that you have specifically authorized in your new client paperwork. If you would like us to exchange information with persons other than yourself an *Authorization for Exchange of Information* form must be completed.

Services for teenagers and their families require special consideration with regard to privacy. It is important to know that the law dictates that parents have the right to examine their child's records (unless we determine that doing so would have a detrimental effect on the therapeutic relationship or the child's physical or psychological well-being). Privacy is essential to effective therapy for teenagers; therefore it is our policy to only provide parents with general information regarding the progress of treatment. Additional information will not be provided to parents unless the child consents or is in danger of harming themselves or others.

Billable Hours
The universal standard for therapy, be it the insurance standards or the professional standards of various organizations like APA, ASHA, etc. is that a therapy "hour" is 45-50 minutes of direct contact with the remaining 10-15 minutes devoted to required record keeping and other administrative requirements. Our company will bill based on the quarter hour system (i.e., 15 minute increments).

Fees
We will always inform you of the associated charges prior to providing any type of clinical service. A schedule of fees can be obtained from our office at any time. Fees apply to various types of services including direct client contact (clinic based or offsite), phone consultations, travel, report preparation and consultation with other professionals. Fees may be adjusted at any time without prior notice.

Late Fees:
A 5% penalty will accrue on all accounts that are past due by more than 30 days.

Payment
The person who signs the *Payment Contract* is responsible for payment of all services rendered. In most cases, payment is due at the time services are rendered unless you have made other arrangements with us

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in advance. Some ongoing services (such as ABA therapy) may be invoiced monthly for your convenience. Payment is due immediately upon receipt of the invoice. Accounts more than 30 days overdue or exceed $1.500.00 will be subject to a $25 late fee and 5% interest charge. Services may also be suspended. Checks returned by the bank will result in an additional charge of $40. Accounts more than 60 days overdue will be sent to collection. For clients seeking third-party reimbursement please be aware that the financial obligation for our services is between you and this office, and **NOT** between us and the insurance company or other agency. You are ultimately responsible for the payment of services rendered.

Health Insurance

Very few insurance companies reimburse for ABA therapy. However, with the passing of AVA's Law we expect this situation to change soon. We will work with insurance companies as reimbursement services become available. Insurance companies covering this service often require pre-certification. The family must obtain any necessary pre-approvals.

The family must provide Beckhom Behavioral Consulting with *complete* insurance or other third- party billing information *before services begin,* or immediately upon commencement of new insurance coverage. Beckhom Behavioral Consulting will not back-bill insurance companies for families who fail to submit insurance billing information in a timely manner. We will file claims to insurance monthly and provide the family with an invoice. The balance of your account is due immediately upon receipt of the monthly invoice, regardless of payment or denial of insurance claims. Billing your insurance company does not guarantee payment. The family is financially responsible for all charges as required by the family's signed contract with Beckhom Behavioral Consulting. Families must consent to having medical benefits paid directly to Beckhom Behavioral Consulting for services rendered. In the event that it is the insurance company's policy to pay to insured member, services will have to be paid for in advance and Beckhom Behavioral Consulting will complete the claims for families to submit themselves for reimbursement.

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Termination of Services

BBC consultants and/or therapists are reimbursed regularly and timely regardless of individual account statuses. When accounts fall unreasonably behind, this becomes difficult to sustain. Consequently, services are subject to discontinuation if payments on unpaid portions of account balance fall more than 60 days delinquent. Services may also be terminated if it is determined that continued participation will be a detriment to the child or family.

Special Reinforcers

If your child likes a special edible reinforcer or is on a special diet, please provide your own primary reinforcers to the consultant.

Special Materials

If your child requires special materials for his/her treatment plan you are expected to provide these items.

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www.beckhombehaviorconsulting.com

NOTICE OF PRIVACY POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with this practice for treatment planning, treatment, and continuity of care. We may disclose it to staff who provide you with treatment through our practice, therapists, tutors, interns, and other professionals or business associates affiliated with our practice for the purposes of billing, quality enhancement, training, audits, and accreditation. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of our firm not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the clients.

Public Safety

Health/Clinical records may be released for the public interest and safety for public health activities, judicial and Administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, ad their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances

Health care/Human service professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child or spouse's records.

Professional Misconduct

Professional misconduct by a health care/human service professional must be reported by other human service professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care/human service professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care/Human service professionals are required to release records of clients when a court order has been placed. In the event of a court order, only the minimally acceptable amount of information will be revealed. Additionally, if a client files a

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complaint or lawsuit against anyone affiliated with the clinic; relevant information regarding the client may be disclosed for the purpose of formulating an appropriate defense.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records unless it is determined that access would have a detrimental effect on the therapeutic relationship, or on the client's physical safety or psychological well-being.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries or copies of the entire clinical record. Only the minimally acceptable amount of information will be released to accommodate such requests.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

Communications with the client outside the clinic setting will only occur as authorized by the client. When it is necessary to contact the client via telephone, messages will not be left on voicemails (or with person's other than the client or the client's legal guardian) unless Beckhom Behavioral Consulting has received written authorization to do so.

Your Rights

You have the right to request to review or receive your medical files. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $.25 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom.

You have the right to request a copy of this notice.

Complaints

If you have any complaints or questions regarding these procedures, please contact Katrina Wilburn-Beckhom at P.O. Box 51293 Albany, Georgia 31703 or call (229) 439-9951. We will get back to you in a timely manner. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either Beckhom Behavioral Consulting or the U.S. Department of Health and Human Rights.

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CLIENT RIGHTS

As a recipient of services at our firm, we would like to inform you of your rights. Below is a description of each of your rights. If at any time you feel your rights have been violated, please contact our office and ask to speak with the Clinical Director.

- You have the right to refuse or terminate services at any time for any reason. Your participation in services is voluntary.
- You have the right to submit complaints or suggestions at any time. We will fully investigate any complaints and seriously consider any suggestions you have for improving the services we provide.
- You have the right to information regarding the cost of services. We will always inform you of associated costs before we provide service. A schedule of fees can also be obtained from our office at anytime.
- You have the right to privacy. Please see our *Notice of Privacy Policy* for information regarding certain limits to confidentiality and how your protected health information will be used.
- You have the right to know under what conditions we will terminate services. Please refer to Beckhom Behavioral Consulting *Policies and Procedures* document for this information.
- You have the right to be informed of any changes in our policies. You will always be notified in the event that we change a policy that is relevant to the services we provide.

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CONSENT FORM

This form must be completed before services can be initiated. If the client is under the age of 18 years, the form must be signed by all legal guardians.

Consent for Treatment
I hereby attest that I have voluntarily applied for and entered treatment, or give my consent for the minor or person under my legal guardianship, at Beckhom Behavioral Consulting. I understand that I may terminate these services at any time.

Receipt of Policies and Procedures
I hereby attest that I have received a copy of the *Policies and Procedures* and have read and understand its content.

Receipt of Client's Rights
I hereby attest that I have received a copy of the Client's *Rights* notice and have read and understand its content.

Receipt of Privacy Policy and Consent for Disclosure of Health Information
I have been provided a copy of Beckhom Behavioral Consulting Notice of Privacy Policies detailing how my clinical record may be used and disclosed under Federal and State law. I understand that as a part of Beckhom Behavioral Consulting treatment, payment, or clinical operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and email only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Beckhom Behavioral Consulting may refuse to treat me or my child. I further understand that Beckhom Behavioral Consulting reserves the right to change its privacy policies and will provide me with a copy of any revised notice.

Photocopy Authorization
I permit a photocopy of this consent form as if it were an original executed consent.

Please initial that you have received and read the following documents:

Policies and Procedures ________
Client's Rights ________
Notice of Privacy Policies ________

Name of Client (Printed) ____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Client's Signature (if 18 years or emancipated): ___________________________ Date____________

For Minors:

Parent/Legal Guardian Signature _____________________________________ Date _________________

Parent/Legal Guardian Signature _____________________________________ Date _________________

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