



## **ABA Therapy and What to Expect**

Welcome to Amazing Transformations! We are honored to have the opportunity to work with your child to provide ABA Therapy. In order to better serve you, we have provided a list of what to expect regarding the provision of ABA services.

- At Amazing Transformations, we believe that children should enjoy learning. We believe in using motivation and reinforcement to shape behavior and maximize progress toward goal mastery. We achieve this by targeting the behaviors and skills that will have the most significant positive impact on your child and your family. We integrate naturalistic teaching methods with intensive teaching procedures so that our clients have the opportunity to learn in the most natural and functional way possible.
- When beginning ABA Therapy, a Board Certified Behavior Analyst, with your input, develops a comprehensive individualized treatment plan with specific goals and interventions.
- An ABA Therapist will be assigned to work directly with your child on the goals included in the treatment plan.
- A supervisor will be assigned to manage your child's case. This supervisor will come to your home periodically (number of hours vary based on insurance approval) to supervise the ABA Therapist, monitor the ABA program, review data, and provide parent/family training when applicable. The supervisor will also create program materials and consult with the ABA Therapist at our office as part of the services provided for your child.
- In addition to working with your child, the ABA Therapist will collect data and also complete a consultation summary at the end of each therapy session. Both the therapist and parent should sign this summary and a copy of the summary will be provided for your records.
- ABA Therapy sessions are scheduled based upon mutual family and therapist availability. A two-hour minimum is required for all sessions.
- Health insurance guidelines indicate that we must address the ABA goals in the approved treatment plan and refrain from addressing academics.
- In order to maximize treatment efficacy, it is important to have an area free of distractions within the home where the ABA Therapist can work with your child.
- Siblings are not permitted to participate in therapy sessions unless specifically requested by the ABA Therapist to address a particular social skill goal.
- A parent or responsible adult must be in the home during all therapy sessions. ABA Therapists and supervisors are not permitted to babysit or watch your child for any amount of time or reason.
- Parent and family training opportunities will be provided as needed or requested in order to generalize mastered skills and effectively address target behaviors.



- In order for us to speak with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared. (attached)
- Detailed Cancellation and Sick Policies are included separately in this welcome packet.
- Our office phone and fax number is 888-859-7749 if should have any questions or need any additional information
- Given their many professional commitments, our professionals may not be immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends). Email communication is also encouraged. We do not provide on-call coverage 24 hours per day, 7 days a week.
- In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

**I have read and understand the description and policies outlined above:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Service Agreement and Consent Form

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operation. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

### **TO PROTECT THE CLIENT OR OTHERS FROM HARM**

If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions, which could include notifying the police, and intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

### **LIMITING, REFUSING, OR WITHDRAWING SERVICES**

Amazing Transformations, LLC has the responsibility and right to make judgments about the advisability of providing service and reserves the right to limit, refuse or withdraw service when:

- There is a perceived danger to staff, whether a risk to their personal safety or to their health
- A client demonstrates a risk of harm or violence to self or others – behavior or situations of concern include:
  - o There is or has been physical or verbal abuse including threatening or intimidating behavior by the client (e.g., record of criminal violence in client's history, previously recorded behavior)
  - o Behavior dangerous to self or others (i.e. repeated aggression or injury sustained from behavior)
  - o Illegal behavior by the client has been witnessed by staff
  - o There is concrete evidence (e.g., through a referral source) that demonstrates potential for high-risk behavior by the client
  - o Where the client's mental health status indicates ABA services would not be helpful
- A client breaks the trust of the organization (e.g., theft or vandalism of Amazing Transformations, LLC property)
- Staff cannot sustain a productive relationship with the client or caregiver



- Parent(s) or caregivers are unwilling to participate in treatment and/or follow through with strategies necessary to promote skill acquisition or behavior change.
- Outside therapies or providers directly contradict ABA services or may negatively impact patient progress OR collaboration with outside service providers and plan of care / service delivery is unable to be agreed upon despite documented attempt(s).
- Amazing Transformations, LLC programs and services are no longer beneficial to the client
- Clients do not pay fees for services where fees exist.
- Services are requested to occur outside of 40 mile service area.
- A client uses discriminatory or harassing language or exhibits discriminatory or harassing behavior, including the refusal to work with a particular counselor because of race, sexual orientation, creed, sex, gender identity, ethnic origin or any other grounds prohibited under the *Human Rights Code*
- The request for service is beyond the limits of Amazing Transformations, LLC resources or expertise.
- A communicable disease is present and there is a risk of transmission.

Amazing Transformations, LLC stands behind a staff decision to limit, refuse or withdraw service or to refer people to alternate community resources for the above reasons provided the circumstances are documented and the approved policies and procedures are followed.

**I have read and agree to the Service Agreement and Consent Form outlined above:**

\_\_\_\_\_

Date: \_\_\_\_\_

## CANCELLATION / SICK/LATE POLICY

Amazing Transformations, LLC strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please discuss schedule changes at the end of your appointment with your therapist or the front desk administrator. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24-48 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday morning appointments our office appreciates being notified no later than Friday noontime. This will allow other clients in need of care to be accommodated.

Sessions will be canceled under the following conditions:

1. If a child misses school due to illness. If a child sees a doctor and the doctor signs a release allowing the child to have a session, this will be honored.
2. If a child has a fever or has had a fever in the last 24 hours
3. If a child has OR has had diarrhea or vomiting within the past 24 hours
4. If a child has a "bad" cold with hacking or persistent cough, green or yellow nasal drainage, these symptoms may be present with or without a fever.
5. If a child has a rash. If a doctor's note is provided that indicates the rash is non-contagious, this rule will be waived.
6. If a child has a contagious condition like lice, pink eye, chicken pox, etc.

Sessions that are canceled with more than 24 hours notice will not be billed. However, if the session is canceled with less than 24 hours notice, a fee of \$100 will be billed. If a staff member arrives at a session and finds that a child fits any of the categories above, the session will be ended and fully billed. *\*\*Note: Insurance companies DO NOT reimburse for cancellation fees; this is the responsibility of the parent(s)/guardian.* \_\_\_\_\_ **Initial**

If a therapy session is cancelled within 24 hours of the appointment time or is missed without any notice, this missed appointment is counted as a no-show (except in cases of emergency), which will result in a charge of a no show fee of \$100. Payment is required for all missed appointments not cancelled according to this policy. *\*\*Note: Insurance companies DO NOT reimburse for no show fees; this is the responsibility of the parent(s)/guardian.* \_\_\_\_\_ **Initial**

In order to maintain exceptional quality of care, services must be provided as regularly as possible. This is achieved through the reliability and consistency of both the therapist and family. In order to achieve this level of quality, we require an 85% attendance rate. If this is not achieved, it may become necessary put services on hold until the matter can be resolved. *Note: We will be tracking schedules, cancellations, etc. and as a courtesy, we will notify you and your therapist if the percentage drops below the required 85%.* \_\_\_\_\_ **Initial**

Chronic cancellations may result in termination of services or cancellation fees. As a courtesy, this will be reviewed with you and put in writing prior to assessing cancellation fees or terminating services. \_\_\_\_\_ **Initials**



- ❖ We request that families give us at least two weeks notice on significant changes in their plans for ABA sessions scheduling in order to facilitate consistency in service delivery. Every effort will be made to accommodate requests for schedule changes. However, significant changes in scheduling are not guaranteed to be accommodated and may result in the need to change therapists if the current therapist does not have availability. \_\_\_\_\_ **Initial**
  
- ❖ Two consecutive no-shows require your child to be placed on an on hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, it may be necessary for your child to be placed on a waiting list until another available therapist can be assigned. \_\_\_\_\_ **Initial**
  
- ❖ The universal standard for therapy, be it the insurance standards or the professional standards of various organizations like the APA, ASHA, etc., is that a therapy: "hour" is 45-50 minutes of direct contact with the patient with the remaining 10-15 minutes devoted to required record keeping and other administrative requirements. Typically, for a 3 hour in-home therapy session, our staff take ~10 minutes to arrange the materials prior to commencing direct therapy with the child and ~ 15 minutes at the end to record data, tidy the setting, and discuss the session with the parent. \_\_\_\_\_ **Initial**

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, such as an extended trip, we will hold your therapy spot for up to three weeks. We will then have to place you on the waiting list and will fit you back in the schedule as soon as we can. **My signature below indicates that I hereby understand and agree to the above service agreement and cancellation policy.**

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Parent or Legal Guardian Signature

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Date



## PERMISSION TO PHOTOGRAPH

I give permission and consent for Amazing Transformations, LLC to photograph my child during the time my child is enrolled in services. I authorize Amazing Transformations to copyright, use and publish the same in print and/or electronically in connection with promoting services.

I agree that Amazing Transformations may use such photographs of my child:

\_\_\_\_\_ WITH identifying information      \_\_\_\_\_ WITHOUT identifying information

Child's name: \_\_\_\_\_

\_\_\_\_\_

Print name (parent/guardian)

\_\_\_\_\_

Signature (parent/guardian)

Date

## PERMISSION TO VIDEOTAPE OR AUDIOTAPE

I give permission and consent for Amazing Transformations, LLC to videotape and/or audio tape my child during the time my child is enrolled in services. I understand these recordings will not be used outside the company and will be kept confidential. I understand that the recordings will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Amazing Transformations, LLC and the client's family.

Child's name: \_\_\_\_\_

\_\_\_\_\_

Print name (parent/guardian)

\_\_\_\_\_

Signature (parent/guardian)

Date



## FINANCIAL INFORMATION

**Payment for services:** may be made via cash, check, credit / debit card, or health insurance (with prior approval). Payments should be made out to **Amazing Transformations and mailed to 500 S. Burnt Mill Road, Voorhees, NJ 08043**. There is a \$40 Returned Check fee for all checks returned by the bank.

**Verifying Insurance Coverage and Benefit Details:** It is your responsibility to verify your medical benefits and patient responsibility (copays / deductibles) with your health insurance company. As a courtesy to you, we may verify benefits with your insurance company as well. However, this is only provide as a courtesy and sometimes insurance companies provide us with inaccurate information. For this reason, it is the responsibility of the client to verify your child’s ABA benefits and patient responsibility for copays, deductibles, and coinsurance. If at any time your health insurance changes while ABA Therapy services are provided it is your responsibility to notify our office immediately and provide a copy of your new insurance card. Any services not covered due to a lack in coverage or failure to notify our office of insurance changes will be your financial responsibility. \_\_\_\_\_ **Initial**

**Billing Copays, Coinsurance, and Deductibles:** It is our policy to invoice families who have services funded through insurance are billed for their portion of financial responsibility AFTER claims have been processed and remitted by the insurance company. This is to ensure that the amount we bill for copays, coinsurance, and deductibles is accurate according to the most up to date information provided by the insurance company. The process to generate and submit claims on our end and for the insurance company to correctly remit payment to us (sometimes this requires several submissions) can take several months. Therefore, you may not receive a bill from Amazing Transformations for the portion you are responsible to pay for several months. Payment is due within thirty (30) days of the invoice date (unless you have contacted the office to make other payment arrangements). Payments should be made out to **Amazing Transformations and mailed to 500 S. Burnt Mill Road, Voorhees, NJ 08043**. There is a \$40 Returned Check fee for all checks returned by the bank. \_\_\_\_\_ **Initial**

**Patient Financial Responsibility:** If we file your insurance claims, you are responsible for co-payment and additional fees not covered by insurance. By initialing, you are acknowledging that you understand this condition of service and commit to promptly remitting payment to Amazing Transformations for all services provided. If your healthcare insurance payer does not cover ABA therapy services, you are required to make self-pay arrangements with Amazing Transformations. \_\_\_\_\_ **Initial**

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Parent or Legal Guardian Signature

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Date





**SCHEDULE AVAILABILITY FORM**

**Instructions:** In the calendar below, please place an "X" in the **timeslots your child is NOT available**. We will be using these forms to match your child's availability with provider availability to schedule sessions/ appointments. The more time your child has available, the higher the probability we will have a match. Please note that afternoon session times are the most popular. If your child can be available at any time before 3:30 on any day, there is a higher probability we will have providers immediately available.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:30						
9:00						
9:30						
10:00						
10:30						
11:00						
11:30						
12:00						
12:30						
1:00						
1:30						
2:00						
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3:00						
3:30						
4:00						
4:30						
5:00						
5:30						
6:00						
6:30						

**Please also indicate your preference for frequency of visits by each provider:**

**ABA Therapist:** \_\_\_\_\_ per week

**Supervisor:** \_\_\_\_\_ per month

**Top 3 session times / days**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_



RELEASE OF PATIENT INFORMATION
EXPLANATION OF YOUR AUTHORIZATION

Table with 2 columns: Question/Topic and Answer/Explanation. Topics include: For Your Protection, The Privacy of Your Health Records, Who will see your protected information, Your Access to Protected Health Records, Others we may share your information with, and Your Right to this Notice.

As required by privacy regulations created as a result of the Health Insurance Portability/Accountability Act of 1996, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED; AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Within this document the patient is referred to as "you." Most of the individuals who are reading this are parents of a patient. As your child's personal representative, reading this notice will inform you of this agency's policies regarding your child's medical information and how it will be handled.



#### Commitment to Privacy:

This agency is committed to maintaining the privacy of your protected health information (PHI). We are required by law to maintain the confidentiality of your health information. We also are required by law to provide you with this notice of our legal duties and privacy practices that we maintain in this clinic concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect.

We recognize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your PHI. Your privacy rights regarding your PHI. Our obligations concerning the use and disclosure regarding your PHI.

#### We May Use and Disclose Your Protected Health Information (PHI) in the Following Ways:

1. **Treatment**-This agency may use your PHI for treatment purposes. We may disclose your PHI to other health care providers for purposes related to your treatment. This may include, but is not limited to, your doctor, other therapists, caseworker, and school related personnel.
2. **Payment**-This agency may use and disclose you PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs.
3. **Health Care Operations**-This agency may use and disclose your PHI to operate our business. An example of this is, using your PHI to evaluate the quality of care you receive from us.
4. **Appointment**-This agency may use and disclose your PHI to contact you and remind you of an appointment. An example of this is, leaving a message on your answering machine.
5. **Release of Information to Family/Friends**-This agency may release your PHI to a friend or family member that is involved in your care. For example, if a friend, babysitter, grandparent, or other family member is with you or your child during the session, they may receive medical information about you or that child.
6. **Disclosures Required by Law**-This agency will use and disclose your PHI when we are required to do so by federal, state, and/or local law.

#### Uses and Disclosure of your PHI in Certain Special Circumstances:

1. **Public Health Risks**-This agency may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of reporting child abuse or neglect, maintaining vital records, preventing or controlling disease, injury or disability, notifying a person regarding a potential risk for spreading or contracting a disease or condition, reporting problems with products or devices, notifying individuals that a product or device they may be using has been recalled.
2. **Revised 01/19/092. Health Oversight Activities**-This agency may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities may include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings**-This agency may use and disclose your PHI in response to a court order, if you are involved in a lawsuit or similar proceedings.
4. **Law Enforcement**-This agency may release PHI if asked to do so by a law enforcement official regarding a crime victim. If we are unable to obtain the person's agreement, concerning a death we believe has resulted from criminal conduct, regarding criminal conduct at our offices, in response to a warrant, summons, court order, or similar legal process, to identify/locate a suspect, material witness, fugitive or missing person, or in an emergency, to report a crime.
5. **Serious Threats to Health and Safety**-This agency may use and disclose your PHI when necessary to reduce or prevent a serious threat to you or your child's health and safety or the health and safety of another individual.
6. **Military**-This agency may disclose your PHI if you are a member of US or foreign military forces and if required by the appropriate authorities.
7. **National Security**-This agency may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. **Inmates**-This agency may disclose your PHI to correctional institutions or law enforcement officials if you or your child is an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care service to you or your child, for the safety and security of the institution and to protect your health and safety or the health and safety of other individuals.



9. **Workers' Compensation**-This agency may release your PHI for workers' compensation and similar programs.

**Your Rights Regarding Your PHI:**

You have the following rights regarding the PHI that we maintain about you or your child. Request involving your rights must be submitted in writing.

1. **Confidential Communications**-You have the right to request that our agency communicate with you about health related issues in a particular manner, or at a certain location. The request must specify the method of contact, or the location where you wish to be contacted. We will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions**-You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. Your request must describe in a clear and concise fashion the information you wish restricted, whether you are requesting to limit our clinic's use, disclosure or both, and to whom you want the limits to apply.
3. **Inspection and Copies**-You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you or your child, including patient medical records, and billing records. This clinic may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.
4. **Amendment**-You may ask us to amend your health information if you believe it is incorrect or incomplete. You may request an amendment for as long as the information is kept by or for this agency. You must provide us with a reason that supports your request for the amendment. Also, we may deny your request if you ask us to amend information that is in our opinion accurate and complete, not part of the PHI, not created by our agency, or the individual/entity that created the information is not available to amend the information.
5. **Accounting of Disclosure**-All of our patients have the right to request an "accounting of disclosures" which is a list of certain non-routine disclosures our agency has made of your PHI for non-treatment, non-payment, or non-operations purposes. Use of your PHI as part of the routine patient care in our clinic is not required to be documented. All requests for an "accounting of Revised 01/19/09 disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before January 31, 2011.
6. **Right to a Paper Copy of this Notice**-You are entitled to receive a paper copy of this notice of privacy practices at any time. A written request is not required.
7. **Right to File a Complaint**-If you believe your privacy rights have been violated, you may file a complaint with this agency's privacy officer, the Office of Civil Rights, or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures**-This agency will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of you or your child's PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care.



### AUTHORIZATION TO RELEASE INFORMATION

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize exchange of information described below between professionals from Amazing Transformations, LLC and the following agency(s) and/or individual(s):

\_\_\_ School District: \_\_\_\_\_

\_\_\_ Healthcare provider(s): \_\_\_\_\_

\_\_\_ Agency(s): \_\_\_\_\_

\_\_\_ Other: \_\_\_\_\_

This authorization applies to the following information: (check each line that applies):

\_\_\_ Educational Data/IEP    \_\_\_ Behavioral/ABA    \_\_\_ Medical

\_\_\_ Psychological    \_\_\_ Social/Development    \_\_\_ Speech/Language

\_\_\_ Other: \_\_\_\_\_

EXPIRATION: This authorization expires (date of event): \_\_\_\_\_

Restrictions: Providers who receive this information may not release it to someone else unless another authorization form is signed.

Withdraw: I know that I can withdraw his consent at any time. To withdraw my consent, I must send a written note to the person or agency in Section 1. The withdraw will be valid as soon as the person or agency gets my note, but will not apply to information that has already been shared after I signed the consent form.

Copy: A copy of this consent form will be as good as the original. I understand that I may request a copy of this consent form at any time.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

CLIENT COPY



## ABA Therapy and What to Expect

Welcome to Amazing Transformations! We are honored to have the opportunity to work with your child to provide ABA Therapy. In order to better serve you, we have provided a list of what to expect regarding the provision of ABA services.

- At Amazing Transformations, we believe that children should enjoy learning. We believe in using motivation and reinforcement to shape behavior and maximize progress toward goal mastery. We achieve this by targeting the behaviors and skills that will have the most significant positive impact on your child and your family. We integrate naturalistic teaching methods with intensive teaching procedures so that our clients have the opportunity to learn in the most natural and functional way possible.
- When beginning ABA Therapy, a Board Certified Behavior Analyst, with your input, develops a comprehensive individualized treatment plan with specific goals and interventions.
- An ABA Therapist will be assigned to work directly with your child on the goals included in the treatment plan.
- A supervisor will be assigned to manage your child's case. This supervisor will come to your home periodically (number of hours vary based on insurance approval) to supervise the ABA Therapist, monitor the ABA program, review data, and provide parent/family training when applicable. The supervisor will also create program materials and consult with the ABA Therapist at our office as part of the services provided for your child.
- In addition to working with your child, the ABA Therapist will collect data and also complete a consultation summary at the end of each therapy session. Both the therapist and parent should sign this summary and a copy of the summary will be provided for your records.
- ABA Therapy sessions are scheduled based upon mutual family and therapist availability. A two-hour minimum is required for all sessions.
- Health insurance guidelines indicate that we must address the ABA goals in the approved treatment plan and refrain from addressing academics.
- In order to maximize treatment efficacy, it is important to have an area free of distractions within the home where the ABA Therapist can work with your child.
- Siblings are not permitted to participate in therapy sessions unless specifically requested by the ABA Therapist to address a particular social skill goal.
- A parent or responsible adult must be in the home during all therapy sessions. ABA Therapists and supervisors are not permitted to babysit or watch your child for any amount of time or reason.
- Parent and family training opportunities will be provided as needed or requested in order to generalize mastered skills and effectively address target behaviors.



- In order for us to speak with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared. (attached)
- Detailed Cancellation and Sick Policies are included separately in this welcome packet.
- Our office phone and fax number is 888-859-7749 if should have any questions or need any additional information
- Given their many professional commitments, our professionals may not be immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends). Email communication is also encouraged. We do not provide on-call coverage 24 hours per day, 7 days a week.
- In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

**I have read and understand the description and policies outlined above: \_\_\_\_\_ Date: \_\_\_\_\_**

Client Copy

## Service Agreement and Consent Form

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operation. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

### **TO PROTECT THE CLIENT OR OTHERS FROM HARM**

If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions, which could include notifying the police, and intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

### **LIMITING, REFUSING, OR WITHDRAWING SERVICES**

Amazing Transformations, LLC has the responsibility and right to make judgments about the advisability of providing service and reserves the right to limit, refuse or withdraw service when:

- There is a perceived danger to staff, whether a risk to their personal safety or to their health
- A client demonstrates a risk of harm or violence to self or others – behavior or situations of concern include:
  - o There is or has been physical or verbal abuse including threatening or intimidating behavior by the client (e.g., record of criminal violence in client's history, previously recorded behavior)
  - o Behavior dangerous to self or others (i.e. repeated aggression or injury sustained from behavior)
  - o Illegal behavior by the client has been witnessed by staff
  - o There is concrete evidence (e.g., through a referral source) that demonstrates potential for high-risk behavior by the client
  - o Where the client's mental health status indicates ABA services would not be helpful
- A client breaks the trust of the organization (e.g., theft or vandalism of Amazing Transformations, LLC property)





- Staff cannot sustain a productive relationship with the client or caregiver
- Parent(s) or caregivers are unwilling to participate in treatment and/or follow through with strategies necessary to promote skill acquisition or behavior change.
- Outside therapies or providers directly contradict ABA services or may negatively impact patient progress OR collaboration with outside service providers and plan of care / service delivery is unable to be agreed upon despite documented attempt(s).
- Amazing Transformations, LLC programs and services are no longer beneficial to the client
- Clients do not pay fees for services where fees exist.
- Services are requested to occur outside of 40 mile service area.
- A client uses discriminatory or harassing language or exhibits discriminatory or harassing behavior, including the refusal to work with a particular counselor because of race, sexual orientation, creed, sex, gender identity, ethnic origin or any other grounds prohibited under the *Human Rights Code*
- The request for service is beyond the limits of Amazing Transformations, LLC resources or expertise.
- A communicable disease is present and there is a risk of transmission.

Amazing Transformations, LLC stands behind a staff decision to limit, refuse or withdraw service or to refer people to alternate community resources for the above reasons provided the circumstances are documented and the approved policies and procedures are followed.

**I have read and agree to the Service Agreement and Consent Form outlined above:**

\_\_\_\_\_

Date: \_\_\_\_\_



CLIENT COPY

## CANCELLATION / SICK/LATE POLICY

Amazing Transformations, LLC strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please discuss schedule changes at the end of your appointment with your therapist or the front desk administrator. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24-48 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday morning appointments our office appreciates being notified no later than Friday noontime. This will allow other clients in need of care to be accommodated.

Sessions will be canceled under the following conditions:

7. If a child misses school due to illness. If a child sees a doctor and the doctor signs a release allowing the child to have a session, this will be honored.
8. If a child has a fever or has had a fever in the last 24 hours
9. If a child has OR has had diarrhea or vomiting within the past 24 hours
10. If a child has a "bad" cold with hacking or persistent cough, green or yellow nasal drainage, these symptoms may be present with or without a fever.
11. If a child has a rash. If a doctor's note is provided that indicates the rash is non-contagious, this rule will be waived.
12. If a child has a contagious condition like lice, pink eye, chicken pox, etc.

Sessions that are canceled with more than 24 hours notice will not be billed. However, if the session is canceled with less than 24 hours notice, a fee of \$100 will be billed. If a staff member arrives at a session and finds that a child fits any of the categories above, the session will be ended and fully billed. *\*\*Note: Insurance companies DO NOT reimburse for cancellation fees; this is the responsibility of the parent(s)/guardian.*

If a therapy session is cancelled within 24 hours of the appointment time or is missed without any notice, this missed appointment is counted as a no-show (except in cases of emergency), which will result in a charge of a no show fee of \$100. Payment is required for all missed appointments not cancelled according to this policy. *\*\*Note: Insurance companies DO NOT reimburse for no show fees; this is the responsibility of the parent(s)/guardian.*

In order to maintain exceptional quality of care, services must be provided as regularly as possible. This is achieved through the reliability and consistency of both the therapist and family. In order to achieve this level of quality, we require an 85% attendance rate. If this is not achieved, it may become necessary put services on hold until the matter can be resolved. *Note: We will be tracking schedules, cancellations, etc. and as a courtesy, we will notify you and your therapist if the percentage drops below the required 85%.*

Chronic cancellations may result in termination of services or cancellation fees. As a courtesy, this will be reviewed with you and put in writing prior to assessing cancellation fees or terminating services.

- ❖ We request that families give us at least two weeks notice on significant changes in their plans for ABA sessions scheduling in order to facilitate consistency in service delivery. Every effort will be made to accommodate requests for schedule changes. However, significant changes in scheduling are not guaranteed to be accommodated and may result in the need to change therapists if the current therapist does not have availability.
- ❖ Two consecutive no-shows require your child to be placed on an on hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, it may be necessary for your child to be placed on a waiting list until another available therapist can be assigned.
- ❖ The universal standard for therapy, be it the insurance standards or the professional standards of various organizations like the APA, ASHA, etc., is that a therapy: "hour" is 45-50 minutes of direct contact with the patient with the remaining 10-15 minutes devoted to required record keeping and other administrative requirements. Typically, for a 3 hour in-home therapy session, our staff take ~10 minutes to arrange the materials prior to commencing direct therapy with the child and ~ 15 minutes at the end to record data, tidy the setting, and discuss the session with the parent.

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, such as an extended trip, we will hold your therapy spot for up to three weeks. We will then have to place you on the waiting list and will fit you back in the schedule as soon as we can. **My signature below indicates that I hereby understand and agree to the above service agreement and cancellation policy.**



**CLIENT COPY**

**FINANCIAL INFORMATION**

**Payment for services:** may be made via cash, check, credit / debit card, or health insurance (with prior approval). Payments should be made out to **Amazing Transformations and mailed to 500 S. Burnt Mill Road, Voorhees, NJ 08043**. There is a \$40 Returned Check fee for all checks returned by the bank.

**Verifying Insurance Coverage and Benefit Details:** It is your responsibility to verify your medical benefits and patient responsibility (copays / deductibles) with your health insurance company. As a courtesy to you, we may verify benefits with your insurance company as well. However, this is only provide as a courtesy and sometimes insurance companies provide us with inaccurate information. For this reason, it is the responsibility of the client to verify your child's ABA benefits and patient responsibility for copays, deductibles, and coinsurance. If at any time your health insurance changes while ABA Therapy services are provided it is your responsibility to notify our office immediately and provide a copy of your new insurance card. Any services not covered due to a lack in coverage or failure to notify our office of insurance changes will be your financial responsibility. \_\_\_\_\_ **Initial**

**Billing Copays, Coinsurance, and Deductibles:** It is our policy to invoice families who have services funded through insurance are billed for their portion of financial responsibility AFTER claims have been processed and remitted by the insurance company. This is to ensure that the amount we bill for copays, coinsurance, and deductibles is accurate according to the most up to date information provided by the insurance company. The process to generate and submit claims on our end and for the insurance company to correctly remit payment to us (sometimes this requires several submissions) can take several months. Therefore, you may not receive a bill from Amazing Transformations for the portion you are responsible to pay for several months. Payment is due within thirty (30) days of the invoice date (unless you have contacted the office to make other payment arrangements). Payments should be made out to **Amazing Transformations and mailed to 500 S. Burnt Mill Road, Voorhees, NJ 08043**. There is a \$40 Returned Check fee for all checks returned by the bank. \_\_\_\_\_ **Initial**

**Patient Financial Responsibility:** If we file your insurance claims, you are responsible for co-payment and additional fees not covered by insurance. By initialing, you are acknowledging that you understand this condition of service and commit to promptly remitting payment to Amazing Transformations for all services provided. If your healthcare insurance payer does not cover ABA therapy services, you are required to make self-pay arrangements with Amazing Transformations. \_\_\_\_\_ **Initial**