Southlake Autism and Behavior Services, PA
355 Citrus Tower Blvd, Suite 116
Clermont, FL 34711
Phone: 352.223.1999 o Fax: 352.600.3119
www.southlakeautism.com

Attendance Agreement

At Southlake Autism and Behavior Services we are committed to providing your child with the utmost in quality ABA services. In order to maintain this level of standard practice, regular attendance is essential. Progress can only occur when children/client attend their sessions regularly and home carryover is completed.

We also understand that children get sick and situations arise which will result in the need to cancel your appointment. Please do us the courtesy of giving at least 24 hours notice if you will not be attending your session. Sessions canceled with fewer than 24 hours of your scheduled appointment will be subject to a fee and may be recorded as an unexcused absence.

After 3 unexcused absences, your child may be placed on a "will call" list. Our Will Call List means your child will no longer be scheduled in a regular weekly time slot. We will call to schedule appointments when we have a cancellation that allows for an opening in the schedule.

We appreciate your understanding of this policy. We are committed to the clients we serve and are devoted to the development of their life skills. In order to allow all clients the opportunity to receive therapy, we cannot hold spots for clients who cancel excessively or who have 3 "no-call, no-show" appointments.

For appointments canceled with fewer than 24 hours notice and for scheduled appointments for which the client does not show with no notice, a No-Show fee of $30.00 will be applied to the client's account and billed to the credit card on file. If no credit card is on file, an invoice will be sent to the Caregiver for payment. Failure to pay the No-Show may result in the client being placed back on the waiting list until their account is in good standing.

Thank you for your help in upholding this policy and ensuring your child attends therapy regularly and consistently. This will only help to maximize the results from the therapy they receive.

Client's Name:_____

Caregiver Signature of Understanding:_____

UNEXCUSED ABSENCES

Absence 1:_____ Caregiver's Signature:_____

Absence 2:_____ Caregiver's Signature:_____

Absence 3:_____ Caregiver's Signature:_____

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Case History & Background Information

Today's Date:_____

Part I: Child and Family History

Child's Name:_____

Date of Birth:_____ Age:_____ Gender: M or F

Delivery: Vaginal C-section Weeks of gestation when the child was born _____

Were there any complications with pregnancy or delivery? Yes No. If yes, please explain

_____

_____

_____

Current diagnosis (all)	age at time of diagnosis
_____	_____
_____	_____
_____	_____

What school does your child attend _____

Grade _____ Is there an IEP in place: yes no

If yes, what was the date of last IEP meeting_____

*please provide us with a copy of the IEP for the last 2 years.

What type of classroom is your child in at school:

mainstream, self-contained, combination

Describe (if any) the special support your child gets at school:

_____

Child's home address:

Language(s) spoken in the home:

Child presently lives with:

Child's primary caregiver(s):

Parent's Full Name:

Date of Birth:

Occupation:

E-mail address:

Business Phone:

Cell phone:

Significant Medical history:

Parent's Full Name:

Date of Birth:

Occupation:

E-mail address:

Business phone:

Cell phone:

Significant Medical history:

Developmental History

At approximately what age did your child do the following?

	Early	Average	Late
Sit			
Crawl			
Walk			
Babble			
Use single words			
Combine 2 words			
Use phrases			
Use sentences			
Ask questions			
Engage in conversation			

Siblings: Name Date of Birth School and grade

1. _____
2. _____
3. _____
4. _____
5. _____

Is there any family history of difficulties similar to those your child is experiencing? Is there any family history of language, learning or developmental delays, mental illness, autism or other pervasive developmental problems? If so, please describe._____

_____

_____

_____

_____

Medications, list all separately:

Name of medication	Dosage Frequency taken	For what diagnosis	Age when medication started	Prescribing doctor
EXAMPLE: **Vyvance**	**10 mg once a day**	**ADHD**	**4 years**	**Dr. Who**

Current Treatment or Intervention:
☐Speech Therapy ☐Occupational Therapy ☐Physical Therapy ☐Behavior Intervention ☐ psychotherapy

List special things your child likes: sugar cookies, Disney movies, toys, etc

Edible	tangible	activity	social	Other

List Food Allergies_____

List Insect Allergies _____

List Drug Allergies _____

If your child's medical history includes any of the following, please report the child's age at occurrence, number of occurrences and any other pertinent information.

Accidents:_____

Allergies:_____

Asthma:_____

Childhood diseases:_____

Colds (persistent):_____

Colic:_____

Ear infections:_____

Eye infections:_____

High fever (persistent):_____

Hospitalizations:_____

Operations:_____

Seizures:_____

Sinusitis:_____

Throat infections:_____

Tonsillitis:_____

Other:_____

_____

Present medical conditions your child is being treated for:

_____

History and Synopsis of concerns:

Describe **what your child spends most of his/her time doing** during the day when with you_____

_____

_____

Describe **what you spend most of your time doing** during the day when with your child_____

_____

_____

Does your child play alone? _____

Has your child had a recent hearing test?_____ Results?_____

Academics: Does your child:

Skill	Yes or No	Only w/ help	independently	Is ability consistent with age? Y N	Refuses
Read					
Identify letters					
Identify numbers					
Cut					
Sit for a story					
Color					
Write Color					
Hold a crayon					
Hold a pencil					
Sit in a chair					
Look when name is called					

Activities of Daily Living:

Skill	Yes or No	Only w/ help	independently	Is ability consistent with age? Y N	Refuses
Brush teeth					
Wipe after toileting					
Wash in the bath					
Pick out clothes					
Use a fork					
Use a spoon					
Drink from open cup					
Drink from sippy cup					
Dress					
Undress					
Tie shoes					

Additional concerns related to daily living skills

_____

_____

_____

_____

Sensory issues your child currently

Describe any Sensory seeking

behaviors_____

_____

Describe any sensory defensiveness

behaviors_____

_____

Self Injurious Behaviors: Does your child self-injure? Yes no

Ex. Head bang, cut, self-bite, skin pick

Describe_____

_____

_____

Safety skill deficits your child

has_____

_____

_____

_____

_____

Does your child feel pain? yes no How do you know?

_____

_____

_____

_____

Transitions: Does your child transition cooperatively from preferred activities to non-preferred activities?

_____

_____

_____

Feeding and Nutrition:

Was your child breastfed or bottle fed?_____

When was your child weaned?_____

Was your child weaned to bottles, cups, or both?_____

Does your child currently drink from bottles, sippy cups, straws, or open cups?

_____

Does your child use utensils independently?_____

Was feeding your child ever difficult? If so, please explain._____

_____

_____

Does your child have any difficulty sucking, chewing, or swallowing? Please describe.

_____

_____

Is your child a picky or fussy eater?_____

Does your child eat a variety of foods? Please check all that apply.

soft_____ chewy_____ crunchy_____

sticky_____ pureed_____ hot_____

cold_____ meats_____ breads_____

fruits_____ vegetables_____ sour_____

sweet_____ spicy_____ dairy_____

If your child does not eat a variety of foods, please describe current diet._____

_____

_____

Fruit	Vegetables	Lean meats	Dairy	Processed meats	Complex carbohydrates	Snack foods	Fast foods	Home cooked Fried foods	drinks	other
.										

Narrow or Limited Interests: Does your child have limited interest in things (only plays with one toy, watches same movie, eats only certain food)_____
_____
_____
_____

Stereotypical Behaviors: Does your child engage in repetitive behaviors such as spinning, hand flapping, echoing things heard, staring at lights, flicking fingers in front of eyes_____
_____
_____

Attending Skills: how long will your child sit and work on one activity_____. What does your child do if requested to complete a nonpreferred activity
_____
_____

Play Skills:

Describe your child's play skills

_____.

What is played with_____. Are toys played with as their intended purpose yes no. Who does your child play with: adults children alone. What does your child's interaction look like when playing with other children_____

_____

Communication Development

When you talk to your child, how much do you feel is understood:

a few words_____ many words and phrases_____

simple directions and questions only_____

almost everything I say_____

How does your child communicate wants and needs? Check all that apply.

cries_____points_____signs_____

pulls toward object_____gestures_____vocalizes sounds_____

uses single words_____uses many words, but only one at a time_____

uses phrases_____uses long sentences_____

Does your child answer when you call?_____

Does your child answer yes/no and wh- questions?_____

Does your child ask for help?_____

Does your child talk about what he/she is doing?_____

What does your child like to talk about?_____

_____

_____

_____

Does your child get stuck on a favorite topic or insist on only talking about what he or she wants to talk about: ie. Disney, dogs, sharks,

What percentage of your child's speech do you understand?_____

Can people outside the family understand your child's speech?_____

Does your child stutter or stammer?_____

Did you ever notice a change in your child's behavior, language, or social skills? If so, please describe the change and when it occurred._____

What are your child's favorite toys and/or play activities?_____

Describe how he/she plays with them?_____

Does your child have any sensory difficulties (tactile, visual, auditory etc.)? If yes, please describe._____

How does your child respond to changes in the environment or routine?_____

How does your child transition from one activity to the next?_____

Does your child prefer to be alone: yes no

Does your child show a preference to be with: adults children animals

Does your child insist on routines: yes no

How does your child gain attention?_____

Who does your child enjoy playing with?_____

_____

Describe how your child interacts with adults and peers._____

_____

_____

_____

Does your child engage in behaviors when things change, are out of order or otherwise different: yes no

Please describe such behaviors:

_____

_____

Present Concerns

Please describe your concerns regarding your child's speech, behaviors, feeding, play, following directions and/or social development._____

_____

_____

_____

_____

When did you first notice the difficulty?_____

_____

Has the problem changed since you first noticed?_____

_____

Is your child aware of the problem?_____

Does your child's communication difficulty cause frustration?_____

_____

What have you done to help your child with these difficulties?_____

_____

Has your child ever been evaluated for therapeutic services? If yes, when and what were the recommended services?_____

Does your child currently attend school or group activities?_____

How do his/her peers and teachers react to the communication difficulty?_____

What do you think will be helpful for your child?_____

What do you hope to gain from this evaluation?_____

Any additional comments or questions?_____

Completed by:_____

Print first and last name signature date

Relationship to child:_____

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WELCOME

Welcome to Southlake Autism and Behavior Services (SABS). SABS is a full service ABA agency helping children, adults and families develop the necessary skills to function successfully in society. We are thankful for the opportunity to work with you. Before services begin, we would like you to know what to expect.

- A complete evaluation of your child will be completed. The evaluation will aid in determining the cause of the concern and set a preliminary course of action.
- Objectives will be targeted and treatment goals will be set.
- A treatment and intervention plan will be developed to meet the treatment goals.
- A behavior analyst will be assigned to your case.
- The services will be provided in the best or natural environment such as your home, your child's school, clinic and community settings.

In order for our services to be successful, your participation is critical. It is important to understand that in order for the behavior of your loved one to change, the behavior, habits and practices of all the individuals in his/her environment will also have to change. Therapy that is behavior analytic driven is an active process and is vastly different from other types of therapy. Your help in collecting data, participating in parent or staff training during sessions and following through in implementing the programs, even when our staff is not there will be an important part of the overall success of this intervention.
We look forward to working with you and your family as we strive to reach the set behavior goals. Please sign this statement of understanding to indicate that you have read this letter and agree to participate in behavioral services.

STATEMENT OF UNDERSTANDING

I, _____, parent/caretaker of _____, have read this letter of understanding regarding provision of behavioral services. I understand that my participation in training during sessions, and in the implementation of the treatment plan is critical to the success of my son or daughter, and therefore, is required. The staff has also explained the company policies to me regarding services. I understand these policies as well.

Parent/Caretaker Signature _____ Date_____

Behavior Analyst _____ Date_____

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Payment Agreement

At Southlake Autism and Behavior Services, PA we are committed to providing your child with the utmost in quality services. In order to maintain this level of standard practice, timely payment must be received for services rendered. Payment is expected at the time of service unless other arrangements have been made in advance, or we are attempting to bill your insurance company. **Please note that insurance coverage does not guarantee payment for ABA services rendered. If your insurance company denies payment for any reason, you will be billed the contracted rate.**

- **For Privately Paying Patients**: Payment will be due at the time of service according to our current rate schedule.

- **For Patients With In-Network Insurance and Medicaid**:
  - Proof of insurance is required prior to your first appointment so that we may gather benefit information and obtain prior authorization if required to do so by your carrier.
  - Any co-pays and/or deductibles are expected at the time of service. This is legally required as per your contract with the insurance company.
  - We will submit therapy claims on your behalf, but please note this is **not a guarantee of payment**. If your insurance company denies part, or all, of the therapy claim, **you will be billed at the contracted rate for your carrier.**
  - We will make reasonable effort to assist you in collecting payment from your insurance carrier. If your insurance company requires submission of information from you directly, you will be expected to do so in a timely manner. **Claims that remain unpaid after 60 days will be billed to you directly.**
  - Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If you have questions about your insurance benefits, please contact your carrier directly. We will happy to provide you with any necessary procedure and diagnosis codes they may require to answer your questions.

- **For Patients With Out-of-Network Insurance**:
  - Payment is due at the time of service using our current rate schedule.
  - We can provide you (upon request) with a receipt/ invoice containing proper coding that you can submit directly to your insurance carrier.
  - Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If you have questions about your insurance benefits, please contact your carrier directly.

- **Non- Payment**: Account balances are expected to be paid prior to your next scheduled therapy session unless other payment arrangements have been made with an authorized Southlake Autism and Behavior Services representative. If your account has not been paid in full within 15 days, therapy will be put on hold until payment has been made. If your account has not been paid within 30 days, a late charge of $25.00 will be applied to your account balance, and every subsequent 30 days thereafter. In the event that we turn this matter over to a collection agency or to an attorney, all fees and costs incurred will be your responsibility.

- **Parents/Caregivers must read and acknowledge the statement below by initialing**

Initial As a courtesy, Southlake Autism makes every effort to advise Parents/Caregivers of what their deductible, copay, coinsurance or any other benefit will or could be. Parents are still required to check with their individual insurance companies to verify their benefits. Southlake Autism does not guarantee any information received from a client's commercial or government insurance company and transmitted to the Parent/Caregiver via voicemail, email, telephonic conversation, United States Postal Service or any other mail carrier to be true or accurate only to the extent that the insurance company provides accurate information related to ABA Services. All parents/caregivers understand that any differences in deductibles, copays, coinsurance or any other benefit information provided by Southlake Autism, as a courtesy, that differs from what their ins. company provides is still binding.

I read, understand, and agree to comply with the Payment Agreement of Southlake Autism and behavior Services.

Patient's Name:_____ Parent's Printed Name: _____

Parent's Signature:_____ Date Signed: _____

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Patient Name (Last, First)	Age	Birth Date	Sex
Mailing Address	City	State / Zip Code	Marital Status
Primary Diagnosis	Primary Numeric Diagnosis	Secondary Numeric Diagnosis	

Insured Parent's Information

Name (Last, First)	Age	Birth Date	Sex	Relationship to Patient
Address (put same if same as above)	City	State	Zip Code	Marital Status
E-Mail Address	Home Phone	Cell Phone		

Pediatrician

Name (Last, First)	Phone	Fax

Primary Insurance Information

Primary Insurance Company	Policy Holder Name		Date of Birth	Policy Number
Insurance Address	City	State	Zip Code	Group Number
Phone Number	**Co-Insurance % Office Use Only**		**Co-Pay Office Use Only**	**Deductible Office Use Only**

Secondary Insurance Information (If Applicable)

Secondary Insurance Company	Policy Holder Name		Date of Birth	Policy Number
Insurance Address	City	State	Zip Code	Group Number
Phone Number	**Co-Insurance % Office Use Only**		**Co-Pay Office Use Only**	**Deductible Office Use Only**

Patient Release

I verify the information I have provided is correct and authorize the release of medical information necessary to process insurance claims to insurance companies and their agencies, for the purpose of filing and payments of medical claims. I also authorize payment of the medical benefits to the provider, Southlake Autism and Behavior Services, PA. I acknowledge a fee at the provider's current rate may be charged on all "past due" balances.

Signature of insured or authorized person, parent	Date Signed

Form E

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Notice of Protected Health Information Privacy Practices
Generalized Consent for Treatment

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

When this document refers to "you" or "your" below, it represents your child or the patient receiving services from Southlake Autism and Behavior Services, PA. The initials SABS are used to represent Southlake Autism and Behavior Services, PA.

As part of the healthcare service you receive from Southlake Autism and Behavior Services, PA, health records are generated and maintained describing your child's care including, but not limited to, your name, address, phone number, social security number, health history, symptoms, examination and test results, diagnoses, procedures, treatments, and plans for future care or treatment. This information is called "Protected Health Information" (PHI). This Notice of Privacy Practices describes how Southlake Autism and Behavior Services, PA may use and disclose your information and the rights that you have regarding your health information.

Uses and Disclosures of Health Information without Authorization

When you obtain services from Southlake Autism and Behavior Services, PA, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment, and to support the operations of the entity and other involved providers. The following categories describe ways that we use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

- Your health information will be used for treatment: For example: Disclosure of medical information about you may be made to therapists, doctors, nurses, technicians, or others who are involved in treating you. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Information may be shared with pharmacies, laboratories, or radiology centers for the coordination of different treatments.
- Your health information will be used for payment: For example: Health information about you may be disclosed so that services provided to you may be billed to an insurance company or a third party for reimbursement of services rendered. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.
- Your health information will be used for health care operations: For example: This information in your health record may be used to evaluate and improve the quality of the care and services we provide.

Disclosures Required by Law or Otherwise Allowed Without Authorization or Notification

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

- When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or for law enforcement; examples would be reporting gunshot wound or child abuse, or responding to court orders
- For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to food, medications, or devices
- For health oversight activities, such as audits, inspections, or licensure investigations
- To organ procurement organizations for the purpose of tissue donation and transplant
- To avoid a serious threat to the health or safety of a person or the public
- Contacting you to provide appointment reminders or to recommend treatment alternatives
- Notifying you of health-related benefits and services that may be of interest to you

Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

Uses and Disclosures Requiring Authorization

Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

YOUR INDIVIDUAL RIGHTS UNDER HIPAA

- You have the right to request restrictions on certain uses and disclosures of your Protected Health Information. For example, you may wish to restrict your employer from knowing about a medical condition. Regardless of your request, please know that the HIPAA rules allow our office to share your Protected Health Information with the Covered Entities. If you wish to restrict your PHI please make this request in writing to SABS and discuss with your therapist.
- You have the right to receive your Protected Health Information in a confidential communication from our office, such as the US mail. If you have a specific request for communication please discuss this with your therapist or Terri Howard, SABS owner.
- You have the right to inspect and copy your Protected Health Information. Copies of your Protected Health Information are available for a reasonable fee paid to our office to cover our expenses of reproducing them. You may request this information at any time via your therapist, the office manager, or Terri Howard, SABS owner.
- You have the right to request that we amend your Protected Health Information. In some cases, we may require that these requests be in writing and be supported by a reason for the change. Generally, this will not apply to such routine changes as address or phone number listings.
- You have the right to receive, upon request, an accounting of your Protected Health Information that we have provided to Non-Covered entities.
- If you have read and responded to this notice through electronic media such as our website or email, you have the right to receive a paper copy of this notice upon request.

If you would like to exercises any of these rights, please contact Terri Howard (SABS owner) at (352) 223.1999 and we will make any necessary arrangements for you.

Southlake Autism and Behavior Services, PA is required by law to maintain the privacy of your Protected Health Information and to provide you with this notice of our legal duties and privacy practices as they apply to your Protected Health Information. We are also required to abide by the terms of this notice, which is currently in effect as of December 15, 2012.

In the future, we reserve the right to change the terms contained in this notice and make any new provisions effective for all of the Protected Health Information we maintain. In the event we elect to change the terms of this notice, a new notice will be posted in our office. In addition, you may receive notification by direct mail, email, or other such communication as our practice may implement from time to time.

Should you ever believe your privacy rights have been violated, we request you to file a complaint with our office by contacting us at (352) 223.1999 or by mail to: 409 East Oakland Avenue, Suite B, Oakland, FL 34787. You may also register your complaint with the Secretary of the US Department of Health and Human Services, Office of Civil Rights. As part of our commitment to you, we value your privacy and take every precaution in our practice to preserve your right to that privacy. Any complaint you file will be used strictly to improve our operating procedures and in no way will you be retaliated against for filing a complaint.

Should you have any questions or concerns, please contact SABS owner Terri Howard directly at (352) 223.1999 to obtain further information.

Generalized Consent for Treatment

I have read and understand the Notice of Protected Health Information Privacy Practices for Southlake Autism and Behavior Services, PA. I understand that if I do not sign this consent form my child cannot be evaluated or treated by Southlake Autism and Behavior Services, PA.

When Southlake Autism and Behavior Services, PA examines, treats, or refers your child, we will be collecting what the law calls Protected Health Information (PHI) about your child. We need to use this information to decide on what treatment is best for your child, provide treatment to your child, and collect payment. We may also share this information with others who provide treatment to your child or need it to arrange payment for your child's treatment or for other business or government functions.

By signing this form you are agreeing to let me use your child's Protected Health Information (PHI) for the purposes of payment, treatment, and health care operations.

Consent to Communicate Through Email, Phone and to Leave Voice Messages

You have a choice and a right to tell us how you want us to communicate your treatment and health information with you, if you are unable to agree to the following: I agree to accept and allow any representative from Southlake Autism and Behavior Services (SABS) to send information regarding treatment to me through email addresse(s) provided to SABS on the initial intake forms and any email address I provide SABS with in the future. I understand that information sent is unencrypted and carries a risk of interception. I agree to hold SABS harmless in the event that my personal, financial or protected health information is accidently, inadvertently or maliciously obtained by outside parties. I agree to allow voice messages to be left on all numbers provided to SABS that contain private and protected health information related to the treatment. I agree to allow SABS representatives to text or respond to my text messages as a means of communication related to therapy sessions, times, locations and the like. I further agree to notify SABS in writing if I desire to make any changes to this consent. I understand that verbal requests of changes cannot be guaranteed to be implemented. I understand I must submit this request in writing and ensure its receipt by the current acting Director of Clinical Services. I understand that only written requests can be honored for changes in communication preferences. Further, I understand that change in my communication preference may not be implemented immediately until all relevant individuals related to my case are notified and then, they are given a reasonable amount of time to make the necessary changes to ensure compliance.

Patient's printed name: _____

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____

Date Signed: _____

Witness: _____

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Release Form

Date _____

I _____ caregiver or guardian of _____
agree to the following:

Photo Release:
I give permission for representatives of Southlake Autism and Behavior Services to take digital images, print and electronically share digital or photographic images of my child(ren) for purposes deemed:

- therapeutic in nature
- to share therapy events with the caregiver
- to use in social stories , schedules or identifiers

I understand my child(ren)'s image may be posted on walls within the therapy center and will be visible to other parents and caregivers.

Walking in the nearby area:
I give permission for representatives of Southlake Autism and Behavior Services to take my child on walks, as appropriate around the Southlake Autism office for therapy related activities that may include; holding hands, staying close by, etc.

Use of bike, scooter, roller-skates/blades:
I give permission to Southlake Autism and Behavior Services to allow my child to learn to use, use, be in the presence of or otherwise participate with various recreational equipment containing one or more wheels.

Toilet Training or Bathroom Assistance:
I give permission for my child to receive bathroom assistance or toilet training. I understand such activities of assistance will include but are not limited to: assistance with wiping, inspecting genital area for cleanliness, assistance with clothing. Further I understand that the needs of my child are unique and my child may require more or less help with the toileting task.

I understand I can revoke my consent to the above by providing a written statement of revocation to Southlake Autism and Behavior Services signed by myself and the DOS.

_____ _____

Parent/ Caregiver Sign Date Witness Sign Date

Southlake Autism and Behavior Services

Speech and Occupational Specialists, LLC

ABELS Academy

355 Citrus Tower Blvd, Suite 116
Clermont, FL 34711
Office 352.223.1999 Fax 352.600.3119

Release of Liability by Consent to Interact or Participate with Physical Structures or Recreational Equipment

I _____ certify that I am a parent or legal caretaker or guardian of (client)_____ and acknowledge and accept the following risks of injury that can occur to the above named client as a result of their interaction with any and all play equipment, gym equipment, therapy equipment, recreational equipment and or any and all other physical item located within the dwelling of or provided by representatives of Southlake Autism and Behavior Services or ABLES Academy or Speech and Occupational Specialists Therapy Group. I agree to release Southlake Autism and Behavior Services or ABLES Academy or Speech and Occupational Specialists, LLC from any and all legal liability.

I willingly acknowledge and accept the following:

- I willingly acknowledge and accept the risk of injury to include but not limited to any and all various degrees of broken skin (not limited to cuts, scrapes, abrasions), bruises, broken bones, internal injuries (not limited to organ punctures, damage, or failure), mental or emotional trauma and behavior or skill regression or death.
- I willingly acknowledge and accept that the above named client may at any time be on physical structures that include but not limited to swings (not limited to pouch or platform), trampolines without a net, large balls, ropes, rock walls and cargo nets that exceed 8 feet in height from the ground, sit upon or stand upon scooters, tricycles, bicycles with and without training wheels, skateboards, roller skates and inline skates; I acknowledge and accept that all structures and equipment mentioned in this consent and any future structures are located on top of cement or tile flooring or asphalt.
- I acknowledge and accept that traffic and community safely skills such as crossing the street and walking with an adult along any road with high speed traffic will be practiced. I acknowledge and accept any risk of injury or death that may result from the above named being within any measurable proximity to moving vehicles.

- I acknowledge that within the above addressed physical location there are many sharp corners that may cause injury if my child should engage in any type of behavior that results in my child's body contacting a sharp corner.
- I willingly acknowledge and accept the risk of permanent injury, death or any other irreparable damage to the body and or mind of the above named client as a result of participation with or being in the presence of any and all structures, located within the physical location or presence of any and all Southlake Autism and Behavior Services or ABELS Academy or Speech and Occupational Specialists, LLC representative.
- I acknowledge and accept that treatment for any and all injuries acquired while in the care of, in the presence of, or on the premises of either Southlake Autism and Behavior Services, ABELS Academy or Speech and Occupational Specialists, LLC or any representative of Southlake Autism and Behavior Services or ABELS Academy or Speech and Occupational Specialists Therapy Group, will be the legal guardian's sole financial responsibly which may include all emergency care, initial care or future care or ongoing treatment as a result of any injury.
- I willingly acknowledge and accept that Southlake Autism and Behavior Services or ABELS or Speech and Occupational Specialists, LLC representative are non-medical persons and their judgment related to injuries will be based on personal experiences only and if an injury occurs that appears to warrant medical or parental attention by a Southlake Autism and Behavior Services or ABELS Academy or Speech and Occupational Specialists, LLC representative a call to 911 will be placed first and then to the parents.
- If an injury occurs that has the appearance of a bruise as evidenced by redness, swelling or discoloration a frozen compress will be applied. If any degree of a skin break occurs, a material covering will be applied.
- I willingly acknowledge and accept the space below is provided for me to provide my specific instructions to be carried out in the event of an injury and that attempts may be made to carry out such a request:

  _____
  _____
  _____
  _____

_____ _____

Legal Caregiver Date Witness Date

Southlake Autism and Behavior Services, PA
355 Citrus Tower Blvd, Suite 116
Clermont, FL 34711
Phone: 352.223.1999 ⊙ Fax: 352.600.3119
www.southlakeautism.com

Credit Card Authorization Form

Client's Name: _____

Responsible Party: _____

Credit Card Information:

Type of Card: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS

Credit Card Number_____-_____- _____- _____ Expiration Date_____/_____

Security Code BACK of Visa OR Master Card: (3 digits) _____

Security Code FRONT of Amex Card: (4 digits) _____

Credit Card Billing Address:

Name as it appears on the Card: _____

Street Address: _____

City: _____State:_____Zip Code: _____

Telephone: _____

I hereby authorize this card to be used for future services and/or final payment.

Cardholder Signature:_____

Date Signed: _____/_____/_____

This Authorization can be faxed to 352.404.5479 or Emailed to: billing@southlakeautism.com

Southlake Autism and Behavior Services, PA
355 Citrus Tower Blvd, Suite 116
Clermont, FL 34711
Phone: 352.223.1999 o Fax: 352.600.3119
www.southlakeautism.com

Authorization for Release of Information

Patients Name _____

Patients Date of Birth _____

Parents Name _____

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of individually identifiable Health information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying SABS in writing. However, the revocation will not have an effect on any actions SABS took before it received the revocation.

I authorize Southlake Autism and Behavior Services to receive from or disclose mine or my family member's individually identifiable health information to the following person(s) or organization(s):

Name: _____

Address: _____

City, State, Zip _____

Phone Number: _____

Description of individually identifiable health information to be received or disclosed (check appropriate type(s) of information):

- ☐ All relevant information related to my healthcare services
- ☐ Treatment Plan(s)
- ☐ Claims
- ☐ Progress Reports
- ☐ Eligibility/Benefits EAP Participation
- ☐ information used to make benefit determinations
- ☐ Health Care Programs - Care Solutions, Behavioral Health, Disease Management
- ☐ Other (describe): _____

The purpose of this authorization is (check all that apply):

- ☐ To allow the appropriate management of treatment, services, and/or coverage under the member's benefit plan.
- ☐ Benefit Management
- ☐ Claims Administration/Payment
- ☐ Subpoena or other legal process
- ☐ Other (describe):

All dates of records will be disclosed unless you indicate differently below.

From_____(MM/DD/YYYY) To _____(MM/DD/YYYY)

THE MEMBER OR MEMBER'S PARENT/REPRESENTATIVE MUST COMPLETE THE REST OF THIS FORM:

I understand that this authorization will expire:

On _____ (MM/DD/YYYY) or one year from the date of the signature below.

_____ _____

Signature of Individual's Parent/Representative Date

Patient's Parent/Representative(s)

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Southlake Autism and Behavior Services, PA
355 Citrus Tower Blvd Suite 116
Clermont, FL 34711
(O) 352.223.1999 (F) 352.600.3119

Release of Medical Information

This release has to do with yours or your child's private medical information. Please read it carefully.

Terms of Acknowledgement and Agreement for Center and Community Based Services:

Center-based services-Your child will receive therapy alone or in groups or group areas in which there are others receiving therapy at the same time. During therapy for your child, there will be interaction with other therapists and with other patients receiving therapy.

Community-based services-Your child will receive therapy in the community.

You acknowledge and understand that by agreeing to receive center-based or community-based services, you agree to the release of the following private health information (PHI) due to the potential of others* being present in the service delivery vicinity (center or community). PHI released may include but is not limited to:

- Various mode of electronic recording not limited to cell phone video, Catalyst recording or audio recording that is intended to share with caregivers or for clinical purposes.
- Others that may be in the service delivery vicinity (center or community) may observe or hear therapy for you/your child's as it is being conducted. This includes information shared between employees of Southlake Autism and Behavior Services during programming hours.
- Others may hear communication between staff about your child's treatment that is necessary to exchange to ensure services are provided effectively. This will occur during supervision of therapy or collaboration with or from one therapist to another.
- Others may hear communication between staff and your child's caregiver during pre and post session reporting that may include caregiver concerns, therapeutic goals and about events during treatment.
- Others may observe your child engaging in appropriate/inappropriate behaviors or learning activities.
- Other unforeseen releases or disclosures that may occur when in the community.

*Others that might be in the service delivery vicinity include: Parents of other children, sibling, caregivers, relatives or other patients we provide services to and private service providers from other companies who provide services during our sessions (clinic or community).

We will work to diligently to protect your child's privacy and private health information by minimizing those in the vicinity when children are having difficulties and refraining from sharing treatment information that is not pertinent to the therapy situation. It also should be understood that as part of ABA services, we may not want to minimize those in the area for therapeutic programming reasons. However, due to the nature of our services and the center and community-based approach, this release of information will likely occur and it is imperative that you understand the nature of the release of information.

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AS IT IS YOUR ADDITIONAL AGREEMENT REGARDING INFORMATION THAT YOU MAY SEE OR HEAR:

I also recognize that when I am in the clinic or community, receiving services or at times when I am not receiving, there is a potential that I might encounter a child, family or caregiver that I might have seen receiving services. I will be responsible with any private health information that I might come in contact with incidentally while I am in the clinic or community setting. Responsible regard for information includes but is not limited to:

- not discussing what I have seen or heard with anyone
- avoiding comments or suggestions to the parent or caregiver
- making statements such as "I recognize that kid from the therapy center"
- making defaming remarks related to behaviors or judgements about the child's outcome

I am aware that the release of this private health information is necessary for Southlake Autism and Behavior Services to be able to provide my child/me with opportunities to learn new behaviors, for the socialization goals of my child, to reduce problem behavior, and for other necessary needs during ABA treatment.

Should you have any specific concerns or you would like to withdraw your release of this information, please speak with Director of Clinical Services Terri Howard. You may withdraw consent for release of this information at any time in writing.

This release will remain in effect as long as I am or my child is receiving services with Southlake Autism and Behavior Services.

I understand that I am releasing personal health information that might be shared due to the nature of receiving services in a center/community based facility. I understand that I can withdraw my consent at any time. I have had the opportunity to ask questions regarding this release.

_____ _____

Parent/Guardian Date

_____ _____

Parent/Guardian Date

_____ _____

Witness Date