Behavioral Outreach Services, LLC

Phone: 731-446-5441	Email: sbeene@behavioraloutreach.com	Fax: 731-784-2664	https://behavioraloutreach.com

Thank you for considering Behavioral Outreach Services as your ABA Provider (Applied Behavior Analysis). We accept most insurance companies, and also work with private pay clients. If you are considering private pay, call us for current rates. Please note, we do try to serve clients as quickly as possible. In some cases we may start ABA services very quickly (after approval has been received from the insurance company – which takes about 4 weeks). In other circumstances you may be on the waitlist for 3-12 months or so. Wait list times vary throughout the year, and are an approximation, not a guarantee of how long the wait will be once on the wait list. Therefore, the quicker you provide ALL required paperwork to us, the sooner we can get you on the wait list for services in order to get started. ***You will ONLY be on the wait list once ALL required paperwork has been received.*** **Thank you for your understanding and patience. If you have any questions, please feel free to contact me at (731) 446-5441 or sbeene@behavioraloutreach.com**

REQUIRED information get on BOS Waitlist to receive ABA services:

Parent Checklist: ✓

- ○ **BOS ABA Intake Paperwork completed, signed, and returned.**
- ○ **Referral from DOCTOR** (MUST be signed by M.D. or Ph.D.) stating these 2 things:
  1.) Diagnosis **(such as Autism, Intellectual Disability, etc.)** with ICD-10 codes
  2.) and says **"refer for ABA services"** (Applied Behavior Analysis services)
- ○ Copy of **front and back of ALL insurance cards** (primary, secondary, etc.)
- ○ A copy of the **MOST RECENT FULL Psychological/Psycho-Educational Evaluation** which diagnosed child with Autism, Intellectual Disability, etc.
- ○ **Email picture** of the child to sbeene@behavioraloutreach.com (for case file).
- ○ A copy of child's IEP or 504 plan from school (if applicable)
- ○ A copy of child's Functional Behavioral Assessment from school (if one has been done)
- ○ A copy of child's Behavior Intervention Plan from school (if one has been done)
- ○ If parents are divorced, we need a copy of custody arrangements
- ○ If you have adopted child or are the legal guardian, we need copies of adoption or guardianship papers.
- ○ Anything else you think is important

BOS Staff USE Checklist

Child:__________________

Date:
1st: 2nd:

Options on How to get Intake Packet and Required Documents to Us:

1.) Scan in and email to sbeene@behavioraloutreach.com (preferred method), or
2.) Fax to 731-784-2664 (preferred method),
3.) Drop off/Mail to current office attn: Shiloh Beene, West TN Hearing and Speech Center, 65 Ridgecrest Rd, Jackson, TN 38305.

Thank You! We look forward to working with you and your family. Sincerely,

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BEFORE YOU FILL OUT THIS ABA INTAKE PACKET-
Please READ the Frequently Asked Questions Below so that you know what our services look like. If you would like our ABA services, Then SIGN that you have read the FAQs and fill out the rest of the ABA Intake Packet.

What is Applied Behavior Analysis (ABA)?

- ABA is a widely used evidence-based treatment for addressing problem behaviors, and teaching communication skills, life skills, and safety skills. Some people also refer to ABA as "Behavior Therapy."
- ABA services take into consideration what is going on before the problem behaviors occur (antecedents), the actual problem behavior itself, and what happens after the problem behavior (consequences).
- At BOS, we also take into consideration a family's values, co-occurring medical and mental health conditions, environmental factors, and assent of child (when appropriate), etc.

Do You Provide Other Services? Yes. We also provide Professional Development Trainings or Workshops for teachers, daycare workers, doctors, nurses and others working with special needs populations in Jackson, TN and surrounding areas.

Where Do the ABA Visits Take Place? Mainly at my office location. Home and community visits will be scheduled as needed. When a school system contracts with us then those ABA services are provided at school.

How Often Are ABA Appointments with the BCBA & RBT?

- Once a week, same day and same time each week at our office location in Jackson, TN.
- Home and community visits will be scheduled as needed.
- Additional RBT services in home or at our office (of up to 40 hours per week) may, or may not, be available due to your child's level of need, RBT location and availability, and limitations of your insurance company.

How Long Do ABA Appointments with BCBA & RBT Last? Allow 1.5 - 2 hours per visit in office location.

What is the Purpose/Goal of ABA Services?

1.) Preventing problem behaviors,
2.) Teaching caregivers HOW to consistently respond to problem behaviors when they occur so that they are less likely to occur in the future
3.) Teaching the caregivers HOW to teach the child socially appropriate communication skills (with words, pictures, or communication device) to get child's wants and needs met the "right way,"
4.) Teaching the caregivers HOW to teach the child life skills, safety skills, and independence skills.

How are these Goals Accomplished?

- Parents/caregivers are given a "behavior book" to write down behavior data. The "behavior book" MUST come with you each week to review during ABA appointments.
- The Behavior Analyst analyzes the behavior data the parents record in order to DETERMINE WHY the child is having problem behaviors, and then develops a behavioral strategies based on that data recorded by parents. **Please note, the Behavior Analyst can not do a proper assessment and recommend proper behavioral strategies/treatment unless accurate behavior data is collected by the parents/caregivers and brought to the ABA appointments.**

Who Participates in the ABA Appointments?

- **BOTH the child and parents** participate during ABA appointments.
- **Our ABA is WORK and takes a bit of energy on both the parents' and child's part. Since you, the parent, are already using a lot of energy parenting, why not FOCUS that energy is such a way that you are being more efficient and reducing problem behaviors over time. It makes good logical sense.**

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Should Us Adults Really Talk About the Child's Problem Behaviors in Front of Them?
YES. We, the adults, discuss what has been going well, and what has not been going well. We also include the child in the conversations as appropriate. Discussing this in front of and/or with the child helps them to process the information and know the difference between good decisions/behaviors and bad decisions/behaviors. It also includes them in some decision-making (when it is possible and/or appropriate) depending upon what we are working on.

By Writing Down Problem Behaviors My Child is Having, am I Saying They Are a Bad Kid?
NO. Not at all. There are no bad kids, just bad behaviors. Problem Behaviors occur because the child lacks certain skills to get their wants and needs met appropriately. Accurately recording details regarding problem behaviors enables us to help you build the skills that you are your child need.

Once we start ABA do Problem Behaviors Slowly Get Better over Time, or How Does That Work?

- Some do and some don't. Once we start implementing new behavioral strategies there could be a temporary increase in problem behaviors. This is called an "extinction burst." It can occur when the problem behaviors no longer get the child what they want. No worries though because we put a heavy emphasis on teaching you HOW to teach the child appropriate ways to get their wants/needs met so that problem behaviors decrease.
- Please note that children will make fast progress in some areas, and slower progress in others. There may even be times where it seems like the child may take "3 steps forward and 2 steps back." This is due to uneven skill development, a child's strengths and weaknesses, caregivers' strengths and weaknesses, and other factors including but not limited to schedules, illness, medications, etc. Not to worry though because progress is progress, and as long as we continue to move in the right direction, we will get there!

If our Child Misses Some School Time Due to ABA Visits, How Do We Get Those Excused?

- We give you 2 copies of the school note at ach ABA appointment in order to excuse them from school (one for you to keep, and one to give to the school).
- You can also make sure it is noted in the child's IEP or 504 plan (if they have one) that they leave school early those days for outside ABA therapy.

How Long Does a Child/Family Usually Receive ABA Services Before They Are Discharged From ABA?

- ***Everyone is completely different from each other.*** Therefore, the length of time that a child receives ABA is completely dependent upon their own unique situation and the progress that is made during ABA.
- Just be aware that OUR JOB IS TO WORK OURSELVES OUT OF A JOB. Our job is to teach the parents/caregivers the tools that they need in order to meet the behavioral goals, then move on to helping the next family.
    - Please note that we will ONLY add 1-2 behavioral strategies/treatments at a time in order to make sure that the family is successful each and every step of the way during ABA therapy. We want to make sure that you fully understand what to do, how to do it, when to do it, what not to do, etc. before we add another strategy.
    - We will work as quickly as possible to meet the behavioral goals, while also ensuring to keep a pace which is comfortable for you and your child.

What Does Being Discharged from ABA Mean?

- You no longer have weekly ABA appointments and no longer have to collect behavior data.
- You DO need to continue using ALL of the behavioral strategies learned in ABA therapy. If you stop using the behavioral strategies, the problem behaviors are likely to return.

What if Problem Behaviors Start Up Again?

- You can go through the ABA Intake Process again to receive our ABA services (there may be a waitlist).
- You can also contact the member services number on the back of your insurance card to get a list of in-network ABA providers if ABA is a "covered benefit" with your insurance company.

Child/Client/Person Supported (Print): ______________________________

Parent/Legal Representative (Sign): ______________________________

Date: ______________________

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DISCRIMINATION IS PROHIBITED

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 REQUIRES THAT FEDERALLY ASSISTED PROGRAMS BE FREE OF DISCRIMINATION. THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION, DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES ALSO REQUIRES THAT ITS ACTIVITIES BE CONDUCTED WITHOUT REGARD TO RACE, COLOR, OR NATIONAL ORIGIN.

Prohibited Practices Include:

3.) Denying any individual any services, opportunity, or **other** benefit for which he or she is otherwise qualified;
4.) Providing any individual with any service or other benefit, which is different or is provided in a different manner from that which is provided to others under the program;
5.) Subjecting any individual to segregated or separate treatment in any manner related to his or her receipt of service;
6.) Restricting any individual in any way in the enjoyment of services; facilities; or any other advantage, privilege, or benefit provided to others under the program;
7.) Adopting methods of administration that would limit participation by any group of recipients or subject them to discrimination;
8.) Addressing an individual in a manner that denotes inferiority because of race, color, or national origin;
9.) Subjecting any individual to incidents of racial or ethnic harassment, the creation of a hostile racial or ethnic environment, and **a** disproportionate burden of environmental health risks on minority communities.

Should you feel you have been **discriminated against, please contact the local Title VI coordinator.** ***Any individual may file a Title VI complaint with the below listed entities. It is preferable that complaints be registered at the local level first.***

LOCAL:

Shiloh Beene, M.S., BCBA, LBA
Owner of Behavioral Outreach Services, LLC,
Licensed Behavior Analyst,
DIDD Approved Behavior Analyst

Cell: (731) 446-5441
Fax: (731) 784-2664
Email: sbeene@behavioraloutreach.com

FEDERAL:

U.S. Department of Health and Human Services, Regional Manager
Office of Civil Rights- Region IV, Atlanta Federal Center, Suite 3B70
61 Forsyth Street,
S.W. Atlanta, GA 30303
Phone: (404) 562-7886

Child/Client/Person Supported (Print): ______________________________

Parent/Legal Representative (Sign): ______________________________

Date: ______________________________

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CONSENTS AND AUTHORIZATIONS FOR SERVICES

Consent for Assessment and Treatment Development: I hereby consent to the assessment process and the potential development of a treatment plan from Behavioral Outreach Services, LLC consistent with a plan of care involving behavior modification techniques, applied behavioral analysis, and/or cognitive behavioral treatments. I confirm that I have been informed and have participated in the assessment process and in planning the care and treatment procedures to be carried out and sign this consent willingly and voluntarily.

Voluntary Informed Consent to Treatment: The potentially harmful effects of the procedures described in the Behavior Support Plan may include any of the following: temporary increase in problem behaviors, a temporary decrease in participation in daily activities, emergence of other inappropriate behavior, avoidance of the situation and/or staff associated with the procedures, attempts to escape the situation and/or staff associated with the procedures. The parent/conservator and/or The Circle of Support also acknowledge and give consent to the fact that hands-on treatment methods may be used to decrease escape from tasks, teach new skills, and/or keep the individual, others, or property safe from harm. The parent/conservator and/or The Circle of Support has evaluated the risks and benefits of using the procedures in the Behavior Support Plan and has determined that the potential benefits derived from these procedures outweigh any potential *harmful effects of* the procedures and the impact of these behaviors on this individual's daily life. The behavioral team follows the ethical guidelines of ensuring that the least restrictive potentially effective procedures are always attempted first, and has chosen only those procedures that are necessary to reduce and/or eliminate the inappropriate behavior and to increase appropriate *behavior.* The parent/conservator and/or The Circle of Support also consents to having Behavior Specialists and/or practicum students implement behavioral treatments, under the direct and/or indirect supervision of a Behavior Analyst. Currently, the individual has no known medical conditions that contraindicate the use of the procedures.

Consent to Video and Photograph: I hereby give Behavioral Outreach Services, LLC permission to take and use my image, whether through photographs or video footage, **for safety and identification purposes**. My signature states that I understand it will only be used for the expressed purpose of developing appropriate behavioral treatments and/or creating a photographic history. We never release information for any sort of marketing purposes without first obtaining a separate release of information for marketing purposes form.

Authorization to Release/Obtain Information: I hereby authorize Behavioral Outreach Services, LLC to release to, or receive from hospitals, schools and school personnel, practicum students or college students, lawyers/paralegals/or court system personnel, physicians, psychiatrists, psychologists, counselors, Speech Language Pathologists, Occupational Therapists, Physical Therapists, Independent Support Coordinators, Behavior Analysts, Behavior Specialists, Supported Living Agencies, WTRO staff, Provider Agency Staff, Circle Of Support Members, Behavior Support Committee Members, Human Rights Committee Members, Conservator/Guardian, Primary Care Physician, Regional Monitors, Direct Care Staff, Third party, i.e., insurance/Medicaide/TennCare/Medicare,etc., other agencies or disciplines, or other individuals involved in my care, all medical records, and information pertinent to the continuity of my care. I hereby give permission for the review of my medical record by the State of Tennessee, Court Monitor, PCP, Provider and ISC. Said information may be electronically transmitted, transmitted by video, audio, verbal, or written means.

***Uses and Disclosures Not Requiring Consent or Authorization:** By law, protected health information may be released without your consent or authorization: Child abuse**,** Suspected sexual abuse of a child**,** Adult and domestic abuse**,** Health oversight activities (i.e., licensing board for psychiatry in Tennessee)**,** Judicial or distractive proceedings (i.e., if you are ordered here by court for an independent child custody evaluation in a divorce), Serious threat to health or safety (is, our "duty to warn" law, national security threats) **,** Workers compensation claims (if you seek to have your care reimbursed under workers compensation, all of your care is automatically subject to review by employer and/or insurer(s).

Provider/Client relationship: I am aware that the relationship between provider and patient is a professional one that precludes ongoing social relationships, giving of gifts, or participation in personal events such as parties, graduations, etc. In addition, I understand that I or another responsible adult must be present during all assessment and treatment sessions in the home/community setting and the BOS practitioner is not solely responsible for the patient during that time. **I agree to notify BOS as soon as possible of cancellation. I understand that repeated cancellations or no shows may result in termination of services.**

I have read the above statements and give my informed consent to the assessment and plan development process, and to the implementation of the Behavior Support Plan. I understand that I may cancel this consent to release information, or consent to treatment at any time by written statement. However, I also understand that any release that has been made prior to my revocation, or any treatment provided prior to my revocation shall not constitute a breach of my right to confidentiality. This authorization to release information, and/or to implement behavioral treatment (a Behavior Support Plan) is automatically revoked at the end of one year from implementation date of BSP, if services are not occurring on a continuous basis.

Child/Client/Person Supported (Print): ______________________________ **Date:** ____________

Client/Parent/Legal Representative (Sign): ________________________________ **Date:** _____________

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Authorization and Consent to Participate in Tele-Health Consultation

The purpose of this form is to obtain your consent to participate in tele-health consultation and remote supervision with the BCBA.

1) **Purpose and Benefits.** The purpose of the tele-health consultation is to enable clients living in rural and/or underserved areas to obtain access to specialists without the time and expense of travel.
2) **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the tele-health consultation. All existing confidentiality protections under federal and State of Tennessee law apply to information disclosed during this tele-health consultation. The consultation is conducted using HIPAA compliant video software. In order to ensure minimal disruption of behavioral services, in times of a health crisis, such as a national or world pandemic, NON-HIPAA compliant modalities of delivering therapy (i.e. telephone calls, video calls, etc.) may be used in place of HIPAA compliant technologies when the federal government allows it.
   Risks and Consequences. The tele-health consultation will be similar to routine BCBA consultation/supervision, except interactive video technology will allow you to communicate with the BCBA at a distance, and will allow the BCBA to observe client/caregiver interactions, and observe the Behavior Specialist or RBT working with the client (if applicable) and provide feedback at a distance. The use of video technology to deliver behavioral healthcare and educational services is a new technology and may not be equivalent to direct client to provider contact.
3) **Rights.** You may withdraw consent for any tele-health session or consultation at any time without impact on your right to future care or treatment, or without risking withdrawal from program benefits to which you would otherwise be entitled to through your insurance carrier. **Please note that the Behavioral Outreach Services Attendance/Sick Policy does apply to scheduled tele-health services as well. Repeated cancellations of behavioral services can lead to discharge from our behavioral services.**

________ I have been advised of all the potential benefits, risks, and consequences the tele-health sessions. I have had opportunity to ask questions about the tele-health sessions and have received answers to any questions that have been posed. I understand the written information provided above.

Child/Client/Person Supported (Print): ____________________________________ **DOB:**___________

Client/Person Supported (if competent adult)/Legal Representative (Sign): ___________________________

Date: _____________________

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HIPAA Release of Information, Media Release Authorization

Here at BOS, we believe that families' voices and points of views should be HEARD. We also believe that progress should be CELEBRATED. Therefore, we are asking your permission to share YOUR SIDE of the story, and YOUR PROGRESS.

I, (parent/legal guardian) ____, grant permission to **Behavioral Outreach Services, LLC, herein after referred to as BOS,** to use my child ________________________________ and family's image/s (photographs and/or video and audio) for use in Media publications including, but not limited to: **Photos, Videos, the BOS Website and/or Affiliates, Bulletin Boards, Slide shows, Training Events, Seminars, Workshops, Social Media Posts (Facebook, Twitter, YouTube, etc.), Email Blasts, Recruiting Brochures, Newsletters, Magazines, General Publications, on the radio, TV, blog, and other media.**

______I understand that any testimonials provided, whether submitted on my own (such as thank you cards, etc.) or solicited (asked for by BOS), whether written and/or video testimonial may be used in connection with publicizing and promoting BOS. I authorize BOS to use my name, brief biographical information, and the Testimonial as defined by my written submission (whether submitted on my own or solicited), or by me in video. I hereby irrevocably authorize BOS to copy, exhibit, publish or distribute the Testimonial for purposes of publicizing BOS' programs or for any other lawful purpose. These statements may be used in printed publications, multimedia presentations, on websites or in any other distribution media.

______I hereby waive any right to inspect or approve the finished photographs, videos, written products, testimonials, or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image/s and/or testimonials. I agree that I will make no monetary or other claim against BOS for the use of the photographs, videos, written products, testimonials, or electronic matter.

______I understand that any personal health information or other information released via the social media platform(s) above may be subject to re-disclosure by such social media platform(s) and may no longer be protected by applicable Federal and State privacy laws.

The following information about me, my family, or my child will not be disclosed:

____

____

______I hereby hold harmless and release Behavioral Outreach Services, LLC from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

______I understand that I have a right to revoke this authorization by providing written notice to BOS. However, this authorization may not be revoked if BOS, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. **I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.**

________I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Child or Adult Client/Person Supported's Name (Print): ___________________________________ **DOB:**_______________

Address:____ City: ________________________ State: _______ Zip: _________

Email:__________________________ Telephone:_______________________

Child/Client/Person Supported (Print): ____ **Date:** ______________

Adult Client /Parent/Legal Representative (Print): ____

Parent/Legal Representative (Sign): ____ **Date:** ______________

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Attendance/Sick Policy **Effective Date: 10/26/2018**

Behavioral Outreach Services, LLC (BOS) values the opportunity to serve our population and understands the importance that consistent attendance and punctuality serves in upholding the integrity of the ABA services we deliver. As a result, BOS strives to establish consistent schedules in order to limit disruptions to therapy. While it is understood that unexpected circumstances arise, and that it is always the right of the parent/guardian to change or cancel an appointment or terminate a session early, BOS has developed the following attendance/sick policy to help prevent the hindrance towards behavioral goals caused by frequency of these occurrences.

OBJECTIVES: This policy serves to maintain the consistency of service delivery, maintain the availability of clinician for the assigned client, and make services available to those who respect the time allotted.

- **No call/no shows:** If clinician does not receive notification of a cancellation or rescheduling by the start time of the scheduled appointment this is considered a no call/no show. The occurrence will be noted in the client's record. Three (3) no call/no shows can lead to an automatic discharge from services.
- **Illness:** Because we are all susceptible to catching the flu, colds, viral infections, and other contagions the following policy is in place- If your child has one or more of the following symptoms we cannot permit them into the clinic and encourage you to attend your regular weekly appointment AFTER all symptoms have cleared. **Fever (101 degrees or higher), Yellow or Green Drainage from the Nose and/or Eye, Vomiting, Diarrhea, Open/Bleeding Lesions, Swelling/Redness in/or Surrounding the Eye, *Hand/Foot/Mouth Disease,* Unknown Rash, Sore Throat/Swollen Glands, Coughing, Lice/Nits or Worms, Known contagious virus, infection, illness, or disease**. Thank you for helping us prevent the spread of infection to the children and staff of BOS. **Contact BOS by phone call or text at 731-446-5441 as soon as possible to notify them of a cancellation.**
- **We follow local, state, and CDC guidelines regarding COVID-19 exposure and illness.**
- **Cancellations:** It is not likely that clinicians will be able to reschedule a session during the same week if cancellations occur. Occurrences of cancellation with less than 24-hour notice will be noted in the client's record. If three (3) sessions in a 90-day period are cancelled with less than 24-hour notice or without a doctor's note, the case will be reviewed for discharge. Late arrivals/early departures of more than 15 minutes will be recorded and treated in the same manner.
- **Protocol for cancelling an appointment: Contact BOS by phone call or text at 731-446-5441 as soon as possible to notify them of a cancellation.** If you call and we are in session with another client and can not answer, leave a message. Preferably, 24 or more hours in advance if possible. If a cancellation was due to sickness, a doctor's note can be turned in to excuse this absence.
- **Abrupt Early Termination of Session:** The parent/guardian always has the right to terminate a session early by simply verbalizing the request that the session cease immediately. In the event of abrupt early termination of a session by a parent/guardian, the occurrence will be noted in the client's record. If three (3) of these abrupt early terminations occur in a 90-day period the case will be reviewed for discharge.
- If ABA services are discontinued at any point due to our agreed upon attendance policy, you as the client have been informed and understand that you can access a list of "in network" ABA providers by contacting the member services number on the back of your insurance card to get a list of ABA providers **IF** ABA is a covered benefit on your insurance policy.

By signing below, Client (if competent adult)/Parent or Legal Representative indicates they have read, agree to, and will abide by the attendance policy.

Child/Client/Person Supported (Print): ____

Client (if competent adult)/Parent/Legal Representative (Sign): ______________________________

Relationship to Client/Person Supported (Print): _______________________ **Date:** ____________

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AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Child/Client/Person Supported Name:____________________________ **DOB:** ____________ SS#: ______________

Street Address: ____ **City/State:** ______ **Zip:** ____________

I hereby authorize Behavioral Outreach Services, LLC to (check all that apply):

❒ Exchange with (Release AND Obtain) ❒ Release to ❒ Obtain from **the parties I have indicated below**

I hereby authorize Behavioral Outreach Services, LLC to exchange / release / obtain information:

❒ Both verbally AND in writing ❒ Verbally only ❒ In written form only

From/to: **Behavioral Outreach Services, LLC**

Description of Information to be Exchanged/Released/Obtained: (Check All That Apply)

- ❑ Educational Records
- ❑ Clinical Records (including behavior analytic, psychological, physical, occupational, speech therapies, etc.)
- ❑ Medical Records
- ❑ Evaluations/Assessments, Eligibility Records

I understand that this information will be used for the following specific purpose: (Check All That Apply)

- ❑ to communicate verbally or in writing regarding behavior issues, attendance issues, challenges at school, medical and/or medication issues, challenges with treatments/therapies, current treatment and/or rehabilitation plan and ensure continuity of care
- ❑ Other:

❑ **N/A**	**From/to: PEDIATRICIAN OR PRIMARY CARE PHYSICIAN** Contact Name: ____ Business Name: ____ Address: ____ City: ____________________________ State: ___________ Zip:______________ Telephone Number: ____________________ Fax Number: ___________________
❑ **N/A**	**From/to: PSYCHIATRIST/ PSYCHOTOPIC MEDICATION MANAGEMENT SPECIALIST** Contact Name: ____ Business Name: ____ Address: ____ City: ____________________________ State: ___________ Zip:______________ Telephone Number: ____________________ Fax Number: ___________________
❑ **N/A**	**From/to: CHILD'S SCHOOL** Contact Name: ____ Business Name: ____ Address: ____ City: ____________________________ State: ___________ Zip:______________ Telephone Number: ____________________ Fax Number: ___________________
❑ **N/A**	**From/to: SLP/OT/PT PROVIDERS** Contact Name: ____ Business Name: ____ Address: ____ City: ____________________________ State: ___________ Zip:______________ Telephone Number: ____________________ Fax Number: ___________________

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❑ **N/A**	**From/to: ____.** Contact Name: ____ Business Name: ______________________________________ Address: ____ City: ____________________________ State: __________ Zip:____________ Telephone Number: ____________________ Fax Number: ___________________
❑ **N/A**	**From/to: ____.** Contact Name: ____ Business Name: ______________________________________ Address: ____ City: ____________________________ State: __________ Zip:____________ Telephone Number: ____________________ Fax Number: ___________________

I understand this release is voluntary and applies to all programs and services operated under the auspices of Behavioral Outreach Services, LLC (BOS). I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that my protected health information, which is disclosed with this release, may be subject to re-disclosure by the recipient and no longer protected by law. **Behavioral Outreach Services, LLC** is not responsible for any alterations made on its medical record copies, which have been released to any party. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. This authorization automatically expires **at completion of ABA services, or by date specified _______________, whichever occurs first. I understand that I may revoke this authorization at any time by notifying Behavioral Outreach Services, LLC in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.** This Authorization for Release of Information is given freely, voluntarily and without coercion.

Client (if competent adult)/Parent/Legal Representative (Sign): ______________________________________

Relationship to Client/Person Supported (Print): ______________________________ Date: _______________

Behavioral Outreach Services, LLC

Phone: 731-446-5441	Email: sbeene@behavioraloutreach.com	Fax: 731-784-2664	https://behavioraloutreach.com

PAYMENT INFORMATION

Child/Client/Person Supported Name: ______________________ Date of Birth: __________

Financially responsible party Name: ______________________ Relationship: __________
Financially responsible party DOB: ______________________ SS#: __________
Billing Address: ______________________
City: ______________________ State:__________ Zip: __________
Phone Number: ______________________ Email:__________
Employer: ______________________ Occupation: __________

Primary Insurance: ______________________ Policy Holder: __________
Insured ID #: ______________________ Insured Group #: __________
Insured Social Security #: ______________________Insured DOB: __________
Insurance Company phone #:______________________

***Make sure to include a copy of the front AND BACK of each insurance card**

Secondary Insurance: ______________________ Policy Holder: __________
Insured ID #: ______________________ Insured Group #: __________
Insured Social Security #: ______________________Insured DOB: __________
Insurance Company phone #:______________________

***Make sure to include a copy of the front AND BACK of each insurance card**

PAYMENT/INSURANCE AUTHORIZATION-AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the doctor agrees otherwise. I understand that unless the named patient has coverage under a managed healthcare plan (i.e. HMO, PPO, EAP) to which I subscribe and in which the Behavior Analyst is a participating provider, I am personally responsible for the payment of all charges. I understand that as a courtesy the will have my insurance claims filed but that it does not release me of responsibility for payment of these charges. Payment for any charges denied or not covered by my insurance company become my responsibility and I agree to pay these charges. I understand that any court order I have is an agreement between the courts and I — not the Behavior Analyst and I am still responsible for all payments. I also understand that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I further understand and agree that a collection agency and/or courts may be used in the event of delinquent payments and that I realize that such action could require the Behavior Analyst to release to the collection parties involved information which identifies me, diagnosis, dates, services rendered and charges as well as any other information needed on the claim filed. In addition, if I have requested the Behavior Analyst have my charges filed to my insurance company I understand that securing benefits under health insurance or other health plans will require that the doctor provide plan management with confidential patient information including diagnosis, service dates and type of services rendered. Further, I understand that for utilization review, quality assurance and other claim review purposes, it may require the Behavior Analyst to provide my confidential information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health claims made by or on behalf of the named patient. This consent shall remain in effect unless all claims have been fully processed and all review procedures completed. **I understand that if any changes to my insurance plan are made that I will notify Behavioral Outreach Services, LLC (BOS) in writing prior to the changes so that a request for services may be submitted to the new plan. I will also provide copies of the front and back of new insurance cards prior to the change. I understand that if I do not notify BOS and services are rendered, I will be responsible for the fees associated with those services**

Client (if competent adult)/Parent/Legal Representative (Sign): ______________________

Date: ______________________

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Behavioral Outreach Services, LLC

Phone: 731-446-5441	Email: sbeene@behavioraloutreach.com	Fax: 731-784-2664	https://behavioraloutreach.com

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW THIS NOTICE CAREFULLY. *This Practice is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care.*

This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when personnel transport patient records to another service location. The information will be maintained under a locked environment at all times (i.e. password protected electronic device, locked vehicle with records out of sight, etc). At no time during transport should the records be accessible by non-personnel. It may be necessary to take client files to a facility where a client is confined or to a client's home where the client is to be examined or treated.

NO CONSENT REQUIRED: The Practice may use and/or disclose your PHI for the purposes of:

a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the insurance program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Practice may also use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

d) Emergency Situations –
   (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

   (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

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e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

f) Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

g) Abuse, Neglect, or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER: The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice:

a) Telephoning the contact number on file and leaving a message on your answering machine or with the individual answering the phone.
b) Texting the contact number on file with the appointment information.

SIGN-IN LOG: The Practice may maintain a sign-in log for individuals seeking care and treatment in the office. Sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS: The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or

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assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION: Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS: You have the right to:

a) Revoke any authorization and/or consent, in writing, at any time. To request a revocation, you must submit a written request to the practice's Privacy Officer.

b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

d) Inspect and obtain a copy of your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy).

g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

h) Receive notice of any breach of confidentiality of your PHI by the Practice.

i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash.

j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

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k) Request copies of your PHI in electronic format.

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Shiloh Beene, at 731-446-5441 or by email at sbeene@behavioraloutreach.com

PRACTICE'S REQUIREMENTS: The Practice:

- is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- is required to abide by the terms of this Privacy Notice.
- reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- will distribute any revised Privacy Notice to you prior to implementation.
- will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS: You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below that is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer is Shiloh Beene.
You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE: This Notice is in effect as of _10_ / _29_ / _18_.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

______________________________________ ____________________
Child/Client/Person Supported Name (please print) Date

_________________________________ _________________________________
Parent/Legal Representative (print) Parent/Legal Representative (sign)

THIS FORM WILL BE PLACED IN THE CLIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Please list below the names and relationships of people to whom you authorize the Practice to release PHI.

______________________________ ___________________________________

______________________________ ___________________________________

______________________________ ___________________________________

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Behavioral Outreach Services, LLC

Phone: 731-446-5441	Email: sbeene@behavioraloutreach.com	Fax: 731-784-2664	https://behavioraloutreach.com

We at Behavioral Outreach Services, LLC understand your need for ABA services as soon as possible, whether that is with our company or with another ABA provider. We want to make sure that you know HOW to check your insurance benefits to see if ABA is a "covered benefit," and how to obtain a list of in-network ABA providers (if ABA is a covered benefit). This will ensure that you have access to a list of in-network providers in case we have a waitlist, as well as provide you with a choice in providers.

If you have Insurance Through Work (PRIVATE COMMERCIAL INSURANCE) then ABA May, or MAY NOT, be a covered benefit. Because ABA is such a specialized service, we want to make sure to tell you EXACTLY how to talk with your insurance company in order to know FOR SURE if ABA is a covered benefit or not. Unfortunately, members have been given incorrect information by their insurance company in the past and were frustrated later to find out that ABA was not a covered benefit (it was specifically excluded). **So, PLEASE follow these instructions exactly as they are written and use the EXACT phrases given** for the best chance at finding out if ABA is a covered benefit on your plan, and how to obtain a list of in-network ABA providers if it is a covered benefit:

1. Call the Member Services/Customer Service telephone number on the back of your insurance card
2. Tell the person that answers **"I need to know if ABA (Applied Behavior Analysis) is ON the EXCLUSIONS LIST, if it is SPECIFICALLY EXCLUDED"** *please note: checking this FIRST will save a lot of time, headache, and potentially incorrect information.* Is ABA on the Exclusions list? (please check) ❑ Yes ❑ No
3. If ABA IS a covered benefit, ask them **"Which diagnosis does the insurance company cover ABA for?"** (Autism, Intellectual Disability, etc.) (write this down)____
4. Ask them for a list of ABA providers that serve your area. If ABA is a covered benefit for your child, they will then give you a list of names and telephone numbers for in-network ABA providers and/or also help you find an ABA provider that may be able to help you as soon as possible
5. Write this information down in regards to your phone call to the insurance company:

Date:_________ Time:_________Name of the person you spoke with__________________________________

Ask for a Call Reference Number (write it down):____

*** If you have a secondary insurance as well (like a TennCare MCO or other commercial insurance), you will want to make sure to choose an ABA provider that it is in-network with both your primary and secondary insurance.**

If you have CoverKids or TennCare (BlueCare, TennCare Select, United Health Care Community Plan, or Amerigroup), then ABA is ***most likely*** a covered benefit if your child has certain diagnosis such as Autism, Intellectual Disability, etc. If you have CoverKids or TennCare, here is how to determine if ABA is a covered benefit for your child, and how to obtain a list of in-network ABA providers:

1. Call the Member Services/Customer Service telephone number on the back of your insurance card
2. Ask to speak with a **"Behavioral Health Case Manager"**
3. Tell them what your child has been diagnosed with (Autism, Intellectual Disability, etc.)
4. Ask them if ABA is a covered benefit for your child. Please be aware that you may need to tell them about the problem behaviors your child is having. IS ABA COVERED? (Check the box) ❑ Yes ❑ No
5. Ask them for a list of ABA providers that serve your area. If ABA is a covered benefit for your child, they will then give you a list of names and telephone numbers for in-network ABA providers and/or also help you find an ABA provider that may be able to help you as soon as possible
6. **Write this information down in regards to your phone call to the insurance company:**

Date: _________ Time:_________ Name of the person you spoke with__________________________________

Ask for a Call Reference Number (write it down):____

**** Please Note:*** *We are* ***no longer in-network with the United Health Care Community Plan (UHCCP) MCO of TennCare.***

By signing below, you acknowledge that you have been informed on how to check your insurance to see if ABA is a covered benefit, and how to obtain a list of in-network ABA providers (if it is a covered benefit) in order to obtain ABA services as soon as possible, whether with BOS or not. You acknowledge that if you choose to get on BOS's waitlist that it DOES NOT stop you from trying to seek ABA services elsewhere so that you can get this service as soon as possible. Please be advised that you can not get ABA services from two different places at the same time. You also agree that if you choose to get on our waitlist, and you obtain ABA elsewhere, that you WILL notify us by phone, text, or email that you no longer need our services so that we can take you off the waitlist.

Client/Person Supported (Print): ____

Client (if competent adult)/Parent/Legal Representative (Sign): __________________________________

Date: ____

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Behavioral Outreach Services, LLC

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Please Note: While some of the questions or information requested may be uncomfortable to answer, it is really important to answer all questions and related information. The information that is being requested is due to requirements from the different insurance companies that we work with in order to get ABA pre-authorized, as well as for treatment purposes and billing purposes.

CHILD/CLIENT/PERSON SUPPORTED INFORMATION

Requested Behavior Analyst____ Date:_______________

How Did you Hear About Us?
Referred by: _____________________________________ Title:_________________________
Address: ______________________________________ Phone:_________________________
Website:____

Child's Name:________________________________ Sex: ______ Age: _____ Date of Birth: ______________
Height: ____________________________________Weight: _______________
Social Security Number: _______-_______-_____
Address:___________________________________ City_______________ St_____________ Zip_________
Main Phone#: ____________________________ Alt Phone #: ____

Ethnicity/Culture:	❑ Caucasian ❑ African- American	❑ Hispanic Origin ❑ Multi-Racial	❑ American Indian, Alaskan Native ❑ Asian or Pacific Islander
Religious Affiliation:	❑ Baptist ❑ Methodist ❑ Church of Christ	❑ Catholic ❑ Pentecostal ❑ Atheist	❑ Non-Denominational ❑ Spiritual, not religious ❑ Other- No set spiritual beliefs
Parent's PRIMARY Language?	❑ English ❑ Spanish ❑ Am. Sign Language	❑ Chinese ❑ Arabic ❑ Other-	**Are you able to read and write in your primary language?** **❑ Yes ❑ No**
Parent's SECOND Language?	❑ English ❑ Spanish ❑ Am. Sign Language	❑ Chinese ❑ Arabic ❑ Other-	**Are you able to read and write in your second language?** **❑ Yes ❑ No ❑ N/A**

PARENT/LEGAL GUARDIAN & FAMILY INFORMATION:

(Circle) Mother/Father: ______________________________ Age: ________ Date of Birth: ________________
Social Security Number: _______-_______-_____
Address:_____________________________________ City_______________ St_______ Zip__________
Main Phone#: ______________ Alt Phone #: _____________________ Email: _____________________
Occupation: ____________________________Employer: ____
Medical History (Please list diagnosis if any): ____
Mental Health History (Please list diagnosis if any): ____
Disabilities (Please list diagnosis if any): ____

(Circle) Father/Mother: ______________________________ Age: ________ Date of Birth: ________________
Social Security Number: _______-_______-_____
Address:_____________________________________ City_______________ St_______ Zip__________
Main Phone#: ______________ Alt Phone #: _____________________ Email: _____________________
Occupation: ____________________________Employer: ____
Medical History (Please list diagnosis if any): ____

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Mental Health History (Please list diagnosis if any): ____
Disabilities (Please list diagnosis if any): ____

Guardian if not parent:________________________________ Age: ________ Date of Birth: ____________
Social Security Number: _______-_______-_____
Address:___________________________________ City_______________ St_______ Zip__________
Main Phone#: ______________ Alt Phone #: _____________________ Email: _____________________
Occupation:___________________________Employer: _______________________________________
Medical History (Please list diagnosis if any): ____
Mental Health History (Please list diagnosis if any): ____
Disabilities (Please list diagnosis if any): ____

If the guardian is not the biological parent, please provide documentation that shows you are the legal guardian and decision maker on behalf of the client.

Brother/Sister (circle): _______________________________ Age:________ Date of Birth: ____________
Medical History, Mental Health History , and/or Disabilities (Please list diagnosis if any): _____________
____

Brother/Sister (circle): _______________________________ Age:________ Date of Birth: ____________
Medical History, Mental Health History , and/or Disabilities (Please list diagnosis if any): _____________
____

Brother/Sister (circle): _______________________________ Age:________ Date of Birth: ____________
Medical History, Mental Health History , and/or Disabilities (Please list diagnosis if any): _____________
____

Brother/Sister (circle): _______________________________ Age:________ Date of Birth: ____________
Medical History, Mental Health History , and/or Disabilities (Please list diagnosis if any): _____________
____

Brother/Sister (circle): _______________________________ Age:________ Date of Birth: ____________
Medical History, Mental Health History , and/or Disabilities (Please list diagnosis if any): _____________
____

Brother/Sister (circle): _______________________________ Age:________ Date of Birth: ____________
Medical History, Mental Health History , and/or Disabilities (Please list diagnosis if any): _____________
____

DIAGNOSIS/REFERRAL INFORMATION:

Primary Care Physician/Pediatrician: ____
Name of Clinic: ____
Address:___________________________________ City_______________ St_______ Zip__________
Main Phone#: ______________ Alt Phone #: _____________________ Email: _____________________
Fax: _________________________________

List Medical Problems/Diagnosis	How Treated?
❑ Autism Spectrum Disorder	
❑ ADHD ❑ ADD	
❑ Intellectual Disability	
❑ Pervasive Developmental Disorder	
❑ Traumatic Brain Injury	
❑ Other:	

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ARI/Form
ATEC-1/11-99

Autism Treatment Evaluation Checklist (ATEC)

Bernard Rimland, Ph.D. and Stephen M. Edelson, Ph.D.
Autism Research Institute
4182 Adams Avenue, San Diego, CA 92116
fax: (619) 563-6840; www.autism.com/ari

Project/Purpose:				
Scores: I	II	III	IV	Total

This form is intended to measure the effects of treatment. Free scoring of this form is available on the Internet at: www.autism.com/atec

Name of Child ____________________ ____________________ ☐ Male Age __________
Last First ☐ Female Date of Birth __________
Form completed by: ____________________ Relationship: ______________ Today's Date __________

Please circle the letters to indicate how true each phrase is:

I. Speech/Language/Communication: *[N] Not true [S] Somewhat true [V] Very true*

N S V 1. Knows own name
N S V 2. Responds to 'No' or 'Stop'
N S V 3. Can follow some commands
N S V 4. Can use one word at a time (No!, Eat, Water, etc.)
N S V 5. Can use 2 words at a time (Don't want, Go home)
N S V 6. Can use 3 words at a time (Want more milk)
N S V 7. Knows 10 or more words
N S V 8. Can use sentences with 4 or more words
N S V 9. Explains what he/she wants
N S V 10. Asks meaningful questions
N S V 11. Speech tends to be meaningful/ relevant
N S V 12. Often uses several successive sentences
N S V 13. Carries on fairly good conversation
N S V 14. Has normal ability to com- municate for his/her age

II. Sociability: *[N] Not descriptive [S] Somewhat descriptive [V] Very descriptive*

N S V 1. Seems to be in a shell – you cannot reach him/her
N S V 2. Ignores other people
N S V 3. Pays little or no attention when addressed
N S V 4. Uncooperative and resistant
N S V 5. No eye contact
N S V 6. Prefers to be left alone
N S V 7. Shows no affection
N S V 8. Fails to greet parents
N S V 9. Avoids contact with others
N S V 10. Does not imitate
N S V 11. Dislikes being held/cuddled
N S V 12. Does not share or show
N S V 13. Does not wave 'bye bye'
N S V 14. Disagreeable/not compliant
N S V 15. Temper tantrums
N S V 16. Lacks friends/companions
N S V 17. Rarely smiles
N S V 18. Insensitive to other's feelings
N S V 19. Indifferent to being liked
N S V 20. Indifferent if parent(s) leave

III. Sensory/Cognitive Awareness: *[N] Not descriptive [S] Somewhat descriptive [V] Very descriptive*

N S V 1. Responds to own name
N S V 2. Responds to praise
N S V 3. Looks at people and animals
N S V 4. Looks at pictures (and T.V.)
N S V 5. Does drawing, coloring, art
N S V 6. Plays with toys appropriately
N S V 7. Appropriate facial expression
N S V 8. Understands stories on T.V.
N S V 9. Understands explanations
N S V 10. Aware of environment
N S V 11. Aware of danger
N S V 12. Shows imagination
N S V 13. Initiates activities
N S V 14. Dresses self
N S V 15. Curious, interested
N S V 16. Venturesome - explores
N S V 17. "Tuned in" — Not spacey
N S V 18. Looks where others are looking

IV. Health/Physical/Behavior:

Use this code: [N] Not a Problem [MI] Minor Problem [MO] Moderate Problem [S] Serious Problem

N MI MO S 1. Bed-wetting
N MI MO S 2. Wets pants/diapers
N MI MO S 3. Soils pants/diapers
N MI MO S 4. Diarrhea
N MI MO S 5. Constipation
N MI MO S 6. Sleep problems
N MI MO S 7. Eats too much/too little
N MI MO S 8. Extremely limited diet
N MI MO S 9. Hyperactive
N MI MO S 10. Lethargic
N MI MO S 11. Hits or injures self
N MI MO S 12. Hits or injures others
N MI MO S 13. Destructive
N MI MO S 14. Sound-sensitive
N MI MO S 15. Anxious/fearful
N MI MO S 16. Unhappy/crying
N MI MO S 17. Seizures
N MI MO S 18. Obsessive speech
N MI MO S 19. Rigid routines
N MI MO S 20. Shouts or screams
N MI MO S 21. Demands sameness
N MI MO S 22. Often agitated
N MI MO S 23. Not sensitive to pain
N MI MO S 24. "Hooked" or fixated on certain objects/topics
N MI MO S 25. Repetitive movements (stimming, rocking, etc.)

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What are some of your child's strengths or things he/she is really good at?

____

____

____

____

How does the Child/Client Communicate?	Please Describe in more detail
❑ Nonverbal, may babble but no effective communication	
❑ Grunts, gestures, points	
❑ American Sign Language	
❑ Has a communication device but we don't know how to use it ❑ Has a Communication Device but doesn't use it often ❑ Has a Communication Device and uses it every day	
❑ Limited vocabulary, Uses 1-3 word phrases	
❑ Complex Speech, no communication problems	

<table>
<tr><th>BACKGROUND INFORMATION</th><th colspan="3">Please Describe and include Dates (when appropriate):</th></tr>
<tr><td>List any Allergies:</td><td colspan="3"></td></tr>
<tr><td>List any Serious Injuries (Include Dates):</td><td colspan="3"></td></tr>
<tr><td>Any Sleep Problem?
-Any problems falling asleep?
-Any problems staying asleep?
-where does child sleep and with whom (if co-sleeping)?
-How are sleep problems being treated?</td><td colspan="3"></td></tr>
<tr><td>Any Problems with Constipation or Bowel Movements?
-If so, how is constipation being treated?
-Is child potty trained to BM in toilet?</td><td colspan="3"></td></tr>
<tr><td rowspan="4">Current Medications: (include Dosage)</td><td>Medication and Dosage</td><td>Prescribed For?</td><td>Prescribed By?</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td rowspan="4">Past Medications: (Include Dosage)</td><td>Medication and Dosage</td><td>Prescribed For?</td><td>Prescribed By?</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Any placement at residential facilities?</td><td colspan="3"></td></tr>
<tr><td>Any Hospitalizations?</td><td colspan="3"></td></tr>
<tr><td>Any Psychiatric Hospitalizations?</td><td colspan="3"></td></tr>
<tr><td>Any Addictive Substances History? (Alcohol, tobacco, sedatives, illegal drugs, caffeine, sugar, etc.)</td><td colspan="3"></td></tr>
</table>

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What are your child's **most favorite foods and drinks**?	
What are your child's **most favorite snacks**?	
Is your child's diet restricted in any way? Will he/she only eat certain foods? If so, please list them here:	
Does your child eat a full meal at the table, or graze throughout the day?	
Does your child receive feeding therapy?	
What are your child's most FAVORITE PLACES to go?	
What is/are your child's most FAVORITE things to play with, or do in the "whole wide world?"	
What could your child absolutely NOT live without? What things mean the most to them?	
What EXACTLY does your child spend the majority of their day doing and/or playing with each and every day?	
Were there major incidents that prompted you to seek behavioral services? If so, please describe and include dates:	
Before problem behaviors occur, there are often some warning signs that the person is about to "act out." What are his /her warning signs that occur right before the problem behaviors occur?	
What do you think contributes to the client engaging in problem behaviors?	
What are some of your child's weaknesses or things he/she needs help with?	
What are some goals that you would like to work on through behavioral services?	

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LEGAL HISTORY:

DCS INVOLVEMENT HISTORY:	
Has the Department of Children Services (DCS) EVER been involved with your family? ❑ NO ❑ Yes – Describe (include dates):	
Have one or more of the children ever been removed from the home by DCS? ❑ NO ❑ Yes – Describe (include dates):	
Is there currently a social worker from the Department of Children Services (DCS) that has contact with your family? ❑ NO ❑ Yes – Describe (include the social workers name and contact information):	DCS Social Worker Name:____________________ Telephone Number: ____________________ Email Address:____________________ Foster Parent Name:____________________ Address: ____________________ Telephone Number: ____________________ Email Address: ____________________
Are there any legal issues involving the child and/or family that may impact ABA treatment? ❑ NO ❑ Yes – Describe (include dates):	
Please describe living situation/custody arrangements of the child. Many Times, there are blended living situations. For example, the child and mom may also live with grandma and grandpa. Please describe your living situation below. Who all lives in the home? Who primarily takes care of the child? Are there grandparents, relatives, or babysitters that also play a major role in the child's life? Please describe:	

ABUSE/NEGLECT/MISTREATMENT HISTORY	Please Check for each	Please describe:
❑ NO Suspected or Known Abuse		
❑ Emotional Abuse?	❑ Suspected ❑ Known	
❑ Verbal Abuse?	❑ Suspected ❑ Known	
❑ Physical Abuse?	❑ Suspected ❑ Known	
❑ Sexual Abuse?	❑ Suspected ❑ Known	
❑ Other- PTSD	❑ Suspected ❑ Known	
❑ Other-	❑ Suspected ❑ Known	

PREVIOUS &CURRENT SERVICES:

Service	Dates of Service	Provider Name, Company Name, Location	Response to treatment
❑ Medication Management			
❑ Psychiatrist			
❑ Counseling			
❑ Applied Behavior Analysis (ABA)			
❑ CCFT			

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(Comprehensive Child and Family Therapy)			
❑ Occupational Therapy			
❑ Speech Therapy			
❑ Physical Therapy			
❑ Play Therapy			
❑ Other:			

SCHOOL INFORMATION:

School Which Child Attends:	
County (School District)	
This School Is:	❑ Public ❑ Private ❑ Homeschool ❑ Alternative ❑ Other
Grade	
Address	
Phone	
Does your child have the following in place at school? (Please Check):	❑ IEP ❑ 504 Plan ❑ Other ❑ Functional Behavioral Assessment (FBA) ❑ Behavior Intervention Plan (BIP)
Which of the following applies to your child's attendance at school? (Please Check):	❑ Child attends school FULL-TIME just like other kids their age ❑ Child attends school PART-TIME ❑ **Child arrives later to school each day due to** ________________ ❑ **Child leaves school earlier each day due to** ____________________ ❑ Child only attends school on the following days: ❑ Child is on Home-Bound and receives education at home
Services Child Reportedly Receives at School:	❑ Speech Therapy ❑ Occupational Therapy ❑ Physical Therapy ❑ ABA ❑ Counseling
Additional Comments:	***Due to Pandemic, it is unknown what school will look like in the upcoming year.**

AVAILABILITY FOR ABA APPOINTMENTS: Please check off **EVERY TIMEFRAME** for **EACH DAY** that you could be available for our set weekly ABA appointments (same day, same time) in our office location. We may or may not be able to accommodate your preferences. Please remember to be flexible in order to give us the greatest chance to meet your needs. Also, for those that may want/need additional support in the home environment by a Registered Behavior Technician, please indicate your additional availability after 4pm. Thank you :)

		Monday	Tuesday	Wednesday	Thursday	Friday
Availability for ABA in Office Location	9 am-10:30am					
	10:30am-12pm					
	1pm-2:30pm					
	2:30pm-4pm					
Availability for possible in-home RBT	4pm					
	5pm					
	6pm					
	7pm					

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QUALITY OF LIFE & SEVERITY CHECKLIST:

HOW CHALLENGING IS IT RIGHT NOW?

***Please check off how you are feeling and what has been happening in past 6 months: ✓**

Things are pretty good for the most part. There may be 1-3 minor behavior challenges per week. We just want to "get a handle on things" before it becomes a big challenge.	
Things are "not the best" and "not the worst." Challenging behaviors occur pretty regularly 4-10 times per week or so. Some of the challenging behaviors may have caused minor scratches (NOT breaking skin), minor bruises, and have NOT caused actual breaking of property.	
Getting sent home from school or daycare due to challenging behaviors ❑ Once ❑ More than once	
Police involvement at school due to challenging behaviors ❑ Once ❑ More than once	
Our marriage (parental relationship) is really strained right now in part due to differences on how to manage the challenging behaviors	
DCS has been involved with our family in past 6 months, but not right now	
DCS is involved with our family right NOW	
Child is VERY QUICK to "trigger." He/she will immediately "blow up" over "little things."	
He/she may be a child, but has the strength of an adult	
Child has made threats of wanting to hurt or kill themselves ❑ Has Never tried to do it ❑ Has tried to harm or kill self	
Child has made threats of wanting to hurt or kill Others ❑ Has Never tried to do it ❑ Has tried to harm or kill Others	
It's pretty intense right now. We are having A LOT of challenges every day, multiple times a day.	
We have separated and/or divorced in large part due to differences on how to manage the challenging behaviors	
Sometimes people and/or animals get hurt due to the challenging behaviors. This has resulted in scratches breaking the skin, significant bruising, and sprains to people and/or animals.	
The challenging behaviors have resulted in SIGNIFICANT sprains, broken bones, etc. requiring a visit to the doctor and/or veterinarian.	
The challenging behaviors have resulted in significant destruction of property such as holes in walls, holes in doors, broken toys, busted windows, broken lights, broken tables and chairs, etc.	
Police Involvement due to challenging behaviors at home/community ❑ Once ❑ More than once	
Has been admitted to inpatient psychiatric care ❑ Once ❑ More than once	
Has been admitted to a residential facility ❑ Once ❑ More than once	

Child/Client/Person Supported (Print): ____

Client (if competent adult)/Parent/Legal Representative (Sign): ________________________________

Date: ____

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Potential High-Risk Behaviors: **Please put a check ☒ beside the problem behaviors that apply to this individual:**	**When did it first start?**	**How Often does this occur per day, week, or month?**	When is it MOST LIKELY to occur?	When is it LEAST LIKELY to occur?
☐ **Self-Injurious Behaviors**- Any action which could hurt oneself by hitting, biting, picking at, slapping, scratching, cutting self, etc. ***(Circle EACH part of the definition that your child has done in the past and/or is currently having a challenge with)***				
☐ **Physical Aggression**- Any action which could hurt others such as hitting, slapping, spitting, biting, throwing things at people, etc. ***(Circle EACH part of the definition that your child has done in the past and/or is currently having a challenge with)***				
☐ **Property Destruction**-Any action which could hurt things by hitting them, throwing them, etc. ***(Circle EACH part of the definition that your child has done in the past and/or is currently having a challenge with)***				
☐ **Elopement-** trying to run away or wander away from supervision. Also includes trying to hid under tables, desks, in closets, etc.				
☐ **PICA-** any attempt to eat inedible objects such as cigarette butts, grass, raw eggs, etc.				
☐ **Theft-** Any attempt to take items which do not belong to you, or without paying for them.				
☐ **Inappropriate Sexual Contact-** Any attempt to have sexual contact with others without their permission including but not limited to attempting to hug on others, kiss on other, and grab others' private parts, etc.				
☐ **Inappropriate Sexual Statements-** Any sexual statements towards others that is socially inappropriate including but not limited to "suck my d*ck, eat my p*ssy, etc."				
☐ **Public Exposure-** Stripping or exposing one's self in public areas (common areas of the home or in public places)				
☐ **Medical Complaints-** faking medical situations like seizures, skin conditions, difficulty breathing, blood poisoning, etc. in order to seek medical attention, and if and when a medical assessment has been done, there was nothing medically wrong identified.				
☐ Other (describe):				

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Potential Medium to Low Risk Behaviors: **Please put a check ☒ beside the problem behaviors that apply to this individual:**	**When did it first start?**	**How Often does this occur per day, week, or month?**	When is it MOST LIKELY to occur?	When is it LEAST LIKELY to occur?
☐ **Inappropriate Toileting**-Urinating or having bowel movements anywhere other than in the toilet (such as on self, floor, closet, etc.)				
☐ **Non-Compliance-** refusal to participate in daily activities				
☐ **Temper Outbursts-** Yelling, whining, crying, kicking, taking off shoes and socks and throwing them, dropping to the ground and refusing to move, etc.				
☐ **Verbal Aggression**- Yelling, cussing, threatening to hurt others, threatening to get staff fired, etc.				
☐ **Stereotypical/Repetitive Behaviors-** making vocal noises repeatedly like "yeeeehing" or other sounds, rocking, pacing, hand to mouth, grinding teeth, hands over ears to block noises, staring at hands in front of face, chewing on blankets and clothing, sniffing things, sniffing people and their feet, crumbling food items and/or pouring drinks just to watch them, "humping," etc.				
☐ **Rigidity-** Obsessive attachment to unusual objects (rubber bands, keys, light switches, etc.), a strong need for sameness, order, and routines (e.g. lines up toys, follows a rigid schedule), gets upset by change in their routine or environment, insistent that you drive a certain way to their favorite place, do things a certain way, etc.				
☐ **Difficulty with Transitions:** between people places activities, etc.				
☐ **Manipulative Behaviors-** asking several people the same question to get what they want, lying, threatening to hurt themselves if they don't get what they want, etc.				
☐ **Hallucinations-** interacting with things that others can not see or hear (i.e. talking with people or things that others can not see or hear, etc.)				
☐ **Delusions-** a belief held with strong conviction despite evidence that it is not true (i.e. believing that someone is out to hurt the person although no one is trying to hurt him/her, etc.)				
☐ Other (describe):				

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