Client Intake Packet
and
Parent Handbook

Key Autism Services

Welcome to Key Autism Services! We are excited that you chose us to help your child unlock their potential. In this packet, you will find all the information that you will need to navigate this process. All issues, no matter how small are equally important to us. We strive to go above and beyond to provide the highest quality services to our clients.

Table of Contents

Contact Information

Phone: 857-829-4040
Fax: 844-965-9105

Email: info@keyautismservices.com

Web: https://www.keyautismservices.com
https://www.facebook.com/KeyAutismServices

Address: 106 Apple Street
Suite 221
Tinton Falls, NJ 07724

Notice Of Information And Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality of your health information, and are required by law to do so. This notice describes how we may use your health information within Key Autism Services and how we may disclose it to others outside Key Autism Services, this notice also describes the rights you have concerning your own health information. We must follow the obligations described in this notice and give you a copy of it. Please review this notice carefully and let us know if you have questions.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We are allowed or required to use or disclose health information about you for certain purposes without your authorization. Certain uses and disclosures of your health information, however, require your authorization. The following are ways in which we may use or share your health information:

Treatment:

We may use your health information to provide you with medical services and supplies. We may also disclose your health information to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, and other facilities involved in your care. For example, we will allow your physician to have access to your medical record to assist in your treatment and for follow-up care.

We also may use and disclose your health information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

Payment:

We may use and disclose your health information to insurers and health plans to get paid for the services or supplies we provide to you. For example, your health plan or health insurance company may ask to see parts of your health information before they will pay us for your treatment.

Health Care Operations:

We may use and share your health information to run our organization, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.

Family Members and Others Involved in Your Care:

Unless you object, we may disclose your health information to a family member or close friend who is involved in your healthcare, or to someone who helps to pay for your care. We also may disclose your health information to disaster relief organizations to help locate a family member or friend in a disaster.

Business Associates:

We may disclose your health information to our third-party service providers ("Business Associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our Business Associate are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

OTHER USES AND DISCLOSURES

Required by Law:

Federal, state, or local laws sometimes require us to disclose patients' health information. For instance, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA. We also are required to give information to Workers' Compensation Programs for work-related injuries.

Public Health Activities:

We may report certain health information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the state government. We also may need to report adverse reactions to medications or medical products to the U.S. Food and Drug Administration (the "FDA"), or may notify patients of recalls of medications or products they are using.

Public Safety:

We may disclose health information for public safety purposes in limited circumstances. We may disclose health information to law enforcement Officers in response to a search warrant or a grand jury subpoena. We also may disclose health information to assist law enforcement Officers in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct within Key Autism Services. We also may disclose your health information to law enforcement officers and others to prevent a serious threat of health or safety.

Health Oversight Activities:

We may disclose health information to a government agency that oversees Key Autism Services or its personnel for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Coroners, Medical Examiners, and Funeral Directors:

We may disclose information concerning deceased patients to coroners, medical examiners, and funeral directors to assist them in carrying out their duties.

Military, Veterans, National Security and Other Government Purposes:

If you are a member of the armed forces, we may release your health information as required by military command authorities or to the Department of Veterans Affairs. Key Autism Services may also disclose health information to federal officers for intelligence and national security purposes or for presidential protective services.

Judicial Proceedings:

Key Autism Services may disclose health information if ordered to do so by a court or if a subpoena or search warrant is served. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your health information.

Marketing/Sale of Information:

We will never sell your information or share your information for marketing purposes unless you give us written authorization. If we contact you for any fundraising efforts, you can ask that we not contact you again.

Information with Additional Protection:

Certain types of health information have additional protection under state and federal law. For instance, health information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and evaluation and treatment for a serious mental illness is treated differently than other types of health information. For those types of information, Key Autism Services is required to get your authorization before disclosing that information to others in many circumstances.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information:

If Key Autism Services wishes to use or disclose your health information for a purpose that is not discussed in this notice, Key Autism Services will seek your authorization. If you give your authorization to Key Autism Services, you may take back that authorization any time, unless we have already relied on your authorization to use or disclose information. If you would ever like to revoke your authorization, please notify the Privacy Officer in writing.

Restrictions on Disclosure of PHI to Health Plan:

Key Autism Services must abide by a request to restrict disclosure of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

WHAT ARE YOUR RIGHTS?

Right to Request Your Health Information:

You have the right to look at your own health information and to get a copy of that information. Please note that exceptions may apply as provided by law. (The law requires us to keep the original record.) This includes your health record, your billing record, and other records we use to make decisions about your care. To request your health information, call or write to the Privacy Officer at the address below. If you request a copy of your information, we will charge you for our costs to copy the information. We will tell you in advance what this copying will cost. You can look at your record at no cost.

Right to Request Amendment of Health Information You Believe is Erroneous or Incomplete:

If you examine your health information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your health information, submit a written request to the address below. We may deny your request but we will respond to your request with an explanation within 60 days.

Right to Get a List of Certain Disclosures of Your Health Information:

You have the right to request a list of many of the disclosures we make of your health information. If you would like to receive such a list, submit a written request to the address below. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost and you may choose to modify or withdraw your request at that time.

Right to Request Restrictions on How Key Autism Services Will Use or Disclose Your Health Information for Treatment, Payment, or Health Care Operations:

You have the right to ask us NOT to make uses or disclosures of your health information to treat you, to seek payment for care, or to operate the system. We are not required to agree to your request, but if we do agree, we will comply with that agreement. If you want to request a restriction, write to the Privacy Officer at the address below and describe your request in detail.

Right to Request Confidential Communications:

You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, please discuss this with your caregiver, or submit a written request to the Privacy Officer at the address below. You can also ask to speak with your health care providers in private outside the presence of other patients – just ask them.

Right to be Notified Following a Breach of Unsecured PHI:

You have the right and will be notified if your health information has been breached as soon as possible, but in any event, no later than sixty (60) days following our discovery of the breach.

Right to Choose a Representative:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure this person has the authority and can act for you before we take any action.

CHANGES TO THIS NOTICE:

From time to time, we may change our practices concerning how we use or disclose patient health information, or how we will implement patient rights concerning their information. We reserve the right to change this notice and to make the provisions in our new Notice effective for all health information we maintain. If we change these practices, we will post a revised Notice of Privacy Practices. You can get a copy of our current Notice of Privacy Practices at any time by requesting one from the Privacy Officer at the address below.

North Carolina Disabilities Rights:

For information on North Carolina disabilities rights you can visit https://disabilityrightsnc.org/ or contact them directly 919-856-2195.

Acknowledgement Of Receipt of Notice of information And Privacy Practices

Patient Name:_____

I have been given a copy of Key Autism Services' ***Notice of Information and Privacy Practices*** ("**Notice**"), which describes how my health information is used and shared. I understand that Key Autism Services has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at 857-829-4040.

My signature below acknowledges that I have been provided with a copy of the Notice of Information and Privacy Practices:

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (*e.g., Guardian, Executor of Estate, Health Care Power of Attorney)*

ABA Treatment

Applied Behavior Analysis (ABA) is an evidenced-based, scientific approach used to improve socially significant behaviors. Key Autism Services ("**KAS"**) employs the procedures of ABA to consumers in home and community settings. These procedures utilize best practices and are implemented by highly trained staff.

Role of the BCBA:

The Board Certified Behavior Analyst (BCBA) is a graduate-level certification in behavior analysis. Professionals who are certified at the BCBA level are independent practitioners who provide behavior-analytic services. In addition, BCBAs supervise the work of Board Certified Assistant Behavior Analysts, Registered Behavior Technicians, and others who implement behavior-analytic interventions.

Role of the Behavior Therapist (BT/RBT):

The Behavior Technician is a paraprofessional who practices under the close, ongoing supervision of a BCBA. The BT is primarily responsible for the direct implementation of behavior-analytic services. The BT does not design intervention or assessment plans. It is the responsibility of the BT Supervisor to determine which tasks an BT may perform as a function of his or her training, experience, and competence.

Scope of Services

KAS provides ABA therapy, an evidenced based treatment for individuals with autism. ABA is the only proven, effective treatment for those with autism. Our BCBA's are ethically responsible to implement behavior analytic procedures that are evidenced based and scientific in nature. Any other strategies cannot be implemented by KAS staff.

If your treatment is funded through your insurance provider, the scope of services is restricted to home and community settings. Therefore, KAS is unable to provide insurance based direct ABA services in an educational setting during educational hours. In addition, treatment plan goals may not be approved by insurance funders if they are academic in nature.

Insurance funders require coordination of care activities between KAS BCBA's and other specialists providing services to our clients. These services include, but are not limited to:

- IEP meetings
- Co-treatment with other specialists
- Doctor appointments
- Phone calls or email correspondence with doctors, teachers, and others who provide services to the client

KAS staff are not permitted to serve as an expert or other witness in legal proceedings, advocate, or other roles that may serve as a dual relationship.

Entrance Criteria

Clients of all ages diagnosed with Autism Spectrum Disorder may be considered for services. KAS offers and provides services without discrimination based upon race, religion, national or ethnical origin, age, sex, sexual orientation, or mental or physical disability. A risk assessment will be conducted at the onset of services to evaluate the client's ability to access services in a home or community setting.

Clinical Discharge Criteria

BCBA's may recommend a clinical discharge of clients if at least one the following criteria is met:

- Treatment is ineffective (may be due to comorbid diagnoses)

- Client has mastered, maintained, and generalized all treatment goals
- Assessment has been conducted and the client does not exhibit any deficits that would require intensive behavior analytic services

Any clinical discharge of services will be done so by transitioning treatment to a lesser level of care until independence.

Physical Management
Regular use of physical management (i.e. protective holds, escorts, etc.) requires written consent from parents or guardians. In the event that a client, staff, or other person involved with the client's care is in imminent risk of serious physical harm, staff may employ physical management strategies without consent for the safety of those involved.

Staffing
All Behavior Therapists participate in a rigorous training process upon hire. Training continues into service with clients on both trained skills and client specific programming. A Board Certified Behavior Analyst (BCBA) conducts all trainings and supervision. Staffing is contingent upon client and staff availability. Any questions or concerns regarding staff training should be directed towards the program BCBA.

Parents can request that a BT or BCBA be removed from a case. Every effort will be made to remedy the concern before removing staff from the case. KAS cannot guarantee the continuance of services if the BT or BCBA cannot be replaced.

Session Hours
ABA services may occur between the hours of 7am-7pm unless otherwise approved.

Program Materials
Any materials, programming, stimuli, reinforcers, etc. made for used or the purposes of a client's program is considered the property of KAS. Parents will not be responsible for reimbursement of those items. Upon discharge of services, parents must coordinate the return of all items associated with the client's program with the BCBA or the Client Services Department. Copies of materials, programming, data, or stimuli can be provided to the client for a reasonable, cost-based fee.

Non-Discrimination and Language Assistance Policy

Key Autism Services complies with a Federal civil rights laws and does not discriminate on the basis of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression. Key Autism Services does not exclude people or treat them differently because of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression.

If applicable, Key Autism Services exerts its best efforts to provide language assistance services to people whose primary language is not English and aids and services to people with disabilities to enable them to communicate effectively with Key Autism Services personnel If you need these services, please contact: 857-829-4040 EXT102

If you believe that Key Autism Services has failed to provide to comply with Federal civil rights laws or has discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Key Autism Services
C/O Don Foster
Mailing Address: 106 Apple Street, Suite 221, Tinton Falls, NJ 07724
Email: don.foster@keyautismservices.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Key Autism Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al don.foster@keyautismservices.com

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele don.foster@keyautismservices.com

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số don.foster@keyautismservices.com

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para don.foster@keyautismservices.com

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 don.foster@keyautismservices.com

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le don.foster@keyautismservices.com

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa don.foster@keyautismservices.com

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звонитеd on.foster@keyautismservices.com

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم تمديد الهاتف don.foster@keyautismservices.com

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero don.foster@keyautismservices.com

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: don.foster@keyautismservices.com

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. don.foster@keyautismservices.com 번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer don.foster@keyautismservices.com

Gujarati: સુચના: જો તમે ગજરાતી બોલતા હો, તો મન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો don.foster@keyautismservices.com

Thai: เรยน: ถ้ ารชวยเหลอทางภาษาไดฟร โทร คุณพูดภาษาไทยคุณสามารถใชบรก don.foster@keyautismservices.com

No Client Solicitation

This agency abides by the Office of the Inspector General of the US Department of Health and Human Services and will not give client items that exceed $10 in value at one time or more than $50 annually. We also go beyond this and abide by the Behavior Analysis Certification Board's Code of Ethics and cannot accept gifts of any amount at any time by anyone.

We will not contact potential customers by phone for solicitation purposes unless the potential client has given written permission to the provider to make contact by phone. If telephone contact is necessary regarding the furnishing of an item or service, it will be completed within a 15 month period preceding the date on which the item or service was provided.

No employee or staff member of Key Autism will solicit, induce or request a testimonial with respect to Key Autism services from any individual receiving services from any Key Autism facility or program or from any family member or responsible party of a Key Autism patient or client. Key Autism Service will not post testimonials, solicited or otherwise, of clients who are actively getting services.

The law allows us to send written communication to you about treatment and healthcare operations including products and services we offer. This is a normal part of provider-client relationship and no permission is required for us to do so. However, communications that are sponsored or reimbursed by a third party whose health care products services or therapies, including ABA materials, which are mailed to you, must be authorized by you. You have the right to revoke the authorization in writing at any time. Our agency will not condition treatment on whether you authorized these communications.

As a provider we may participate in public events (health fairs) and mass mailings to clients/potential clients to inform them about new products or services. Once a client contacts us, we may follow up in order to clarify an appointment time or assess satisfaction with a service or item received.

Providers/staff providing an order for a service, will receive a report of the findings and recommendations. Client data will not be shared with any other health provider or family member without specific permission.

Policies and Procedures for Filing Grievances

Although informal resolution of treatment or billing related situations is encouraged, there may be situations in which formal consideration and resolution is necessary. All ABA treatment concerns should be directed to program BCBA's. If the grievance is not satisfactory resolved, the client may submit a written or oral statement to the Director of Clinical Services: support@keyautismservices.com.

Any operational or billing related concerns should be directed to the Client Services Department. If the grievance is not satisfactorily resolved, the client may submit a written or oral statement to the Director of Operations: support@keyautismservices.com.

At any time during this process, you may contact your insurance company.
No form of retaliation shall occur nor any impact to service be created as a result of a grievance. All documentation regarding the grievance will be filed in the client's case record.

Client Illness Policy

The Client Illness Policy protects the health of all of our clients, their families, and our service providers. Clients, their families, and our service providers should adhere to these policies to prevent the spread of infectious disease or illness. Some of our clients or staff may have compromised immune systems or the inability to fight infections. This policy protects all clients and staff from the infectious disease or illness.

Services must be cancelled in the event of any of the following symptoms present in the client with or without the use of medication within 24 hours of a session:

- A temperature of 100.4 or higher
- 2 consecutive occurrences of diarrhea (not associated with any medical conditions)
- 1 occurrence of vomiting (not associated with any medical conditions)
- Rashes (excluding diaper rash)
- Green or yellow discharge
- Extreme irritability or exhaustion
- Eye infection
- Hacking or persistent cough
- Productive cough with green or yellow phlegm
- Absence in school or other therapies due to illness

Any family members experiencing these symptoms must be separated from clients and providers while sessions occur. In the event that a family member experiences a highly contagious illness (i.e. pink eye, hand-foot-mouth disease), sessions must be cancelled until symptoms have been resolved.

Staff may terminate a session at any time that they identify a client is unable to access treatment because of illness.

Staff will cancel a session in the event that they exhibit symptoms that may expose a client to illness.

Please acknowledge that you have read and understand the foregoing policy by placing your initials here: _____

Service Location Health and Safety Policy

Clients and families are responsible to provide a location that is both safe and healthy for our staff to provide treatment. In the event that the service location has been deemed unsafe or unhealthy, clients and families have the option to provide another location for service delivery. If another location is not provided, services will be suspended until a healthy and safe service delivery location can be identified.

The following situations (examples, not limited to), may be considered unsafe or unhealthy for treatment:

- Bed bugs
- Rodent or insect infestation
- Carbon monoxide leaks
- HVAC problems (no air conditioning for daytime temperatures over 80 degrees, no heat for daytime temperatures less than 32 degrees)
- Illegal drugs present
- Family members or adults present incapacitated
- Active domestic violence

If any of these situations are present, families should notify the case BCBA and Client Services Coordinator to arrange for a suspension in services or for services to occur at another location

If any of these situations are present during the session, Key Autism Services staff reserve the right to immediately terminate the session.

In the event that staff are actively unsafe, Key Autism Services staff reserve the right to terminate the session and ensure the safety of themselves and other vulnerable individuals.

Please acknowledge that you have read and understand the foregoing policy by placing your

initials here: _____

Parent Participation Policy

Parent participation is an integral component of a successful ABA treatment program. Parent/caregiver participation is required to receive insurance-based ABA services.

BCBA's are responsible for determining an appropriate frequency and duration of parent training sessions based upon assessment. Parents can request an increase in the frequency or duration of those services as long as they do not exceed authorized insurance hours.

A Responsible Adult over the age of 18 is required to be present throughout each ABA session. Responsible Adults include parents, teachers, grandparents, babysitters, nanny's, or any other adult identified by the family is writing to provide for the health and welfare of your child while the parent is not present.

The Responsible Adult is responsible for feeding, monitoring a child's health, bathroom routines, and overall safety unless treatment goals are identified which would involve staff involvement. Responsible Adults must be present in each of these situations regardless of their involvement.

KAS staff are unable to provide transportation for your child. Siblings are welcome to be part of a client's natural environment, however, it may not always be appropriate for them to be present when treatment is in session. Responsible adults must supervise siblings at all times during ABA treatment sessions.

The staff at KAS strives to develop and maintain a constructive parent/staff relationship. Please interact with all staff in an appropriate manner. In you have concerns regarding your child's programming, please contact the program BCBA.

Please acknowledge that you have read and understand the foregoing policy by placing your initials here: _____

Client Cancellation and Extended Leave Policy

Key Autism Services strives to promote positive change for the children that we support. ABA Therapy is most effective when provided consistently as prescribed. Client and family participation is critical in the implementation of ABA services and consistent attendance is necessary for client progress.

Families should make every attempt to cancel as soon as possible before a scheduled session. Cancellations should occur no less than 48 hours before a scheduled session. The following people should be contacted in the event of a cancellation:

Send an email to:

- Cancellations@keyautismservices.com
- Behavior Therapist
- BCBA
    - Email should state the client's name, date of cancellation, session time, assigned Behavior Therapist and BCBA names

Excessive cancellations may be considered anything more than 1 per month. In the event of excessive cancellations, Key Autism Services may suspend or discharge services. If, at any time you are unable to maintain the agreed upon scheduled sessions, contact a Client Services Coordinator at 857-829-4040 Ext 102 to discuss options to maintain services.

An adult over the age of 18 is required to be present at each session. This can be a parent, guardian, or any adult designated by the parent. This adult is required to be present in the home or community throughout the entire session. If an adult is not present, the session will be cancelled by the staff.

Any vacation/extended absence for longer than 2 weeks, KAS cannot guarantee continuation of therapy upon your return.

Please acknowledge that you have read and understand the foregoing policy by placing your initials here:_____

E-MAIL/Text Communication Consent

Risk of using email

Transmitting client information by E-mail has a number of risks that clients should consider before using E-mail. These include, but are not limited to, the following risks:

- The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from the Agency are not encrypted, so E-mails may not be secure. Therefore, it is possible that the confidentiality of such communications may be breached by a third party
- E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- E-mail senders can easily misaddress an E-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect E-mail transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems. Agency server could go down and E-mail would not be received until the server is back on-line.
- E-mail can be used as evidence in court.

Conditions for the use of email

The Agency will use encrypted emails to maintain security and confidentiality of E-mail information sent and received containing client confidential information. Agency and Staff are not liable for improper disclosure of confidential information that is not caused by Agency's or Staff's intentional misconduct. Clients must acknowledge and consent to the following conditions:

- E-mail is not appropriate for urgent or emergency situations. Agency and Staff cannot guarantee that any particular E-mail will be read and responded to within any particular period of time.
- If the client's E-mail requires or invites a response from Agency or Staff, and the client has not received a response within two (2) business days, it is the client's responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond.
- E-mail must be concise. The client should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
- All E-mail may be printed and filed in the client's medical record.
- Office staff may receive and read your messages.
- Agency will not forward client identifiable E-mails outside of the Agency without the clients prior written consent, except as authorized or required by law.
- The client should not use E-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Agency is not liable for breaches of confidentiality caused by the client or any third party.
- It is the client's responsibility to follow up and/or schedule an appointment if warranted.
- This consent will remain in effect until terminated in writing by either the client or Agency.
- In the event that the client does not comply with the conditions herein, Agency may terminate client's privilege to communicate by E-mail with Agency.

Conditions for the use of Text

- Both families and staff can use text messaging to notify the late start of a session, session cancellation, or change in session time. KAS staff cannot initiate or respond to any text message communications that may disclose the confidential information of the client.
- Any confidential information (including pictures and videos) that are shared with KAS staff are done so at the risk of potential disclosure.
- Families and staff are permitted to use text messaging to communicate during hours of operation only. If communication needs to occur outside of those times, it should be done through email. Only under extenuating circumstances (i.e. cancellation of a session that begins at 7am) is communication through text message permissible outside of these hours.

Communication Instructions

- Avoid use of his/her employer's computer/phone
- Put the client's acronym in the message.
- Key in the topic (e.g., medical question, billing question) in the subject line.
- Inform Agency of changes to contact information.
- Acknowledge any communication received from the Agency and/or Staff.
- Take precautions to preserve the confidentiality of communications.
- Protect his/her password or other means of access to E-mail/text.

Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail/Text between the Agency, Staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Agency may impose to communicate with client by E-mail/Text. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge Key Autism Services and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail/Text.

_____ _____

Parent/Caregiver Signature Date

_____

Printed Name

Policy on Use of Email to Transmit Health Information

It is the policy of Key Autism Services to use secure, encrypted email when transmitting your protected health information (PHI) by email to you or to a person you have designated to receive your PHI.

However, from time to time, our clients request that we use regular unsecured email (e.g., gmail) to deliver their PHI either to them or to third parties they have designated. Sending protected health information by unsecured email carries two substantial risks:

1. The email could be sent to the wrong person because of a typing mistake or selecting the wrong name in an auto-fill list
2. The email could be accessed electronically while in transit.

These risks mean that use of regular, unsecured email to transmit your PHI could result in disclosure of your PHI to individuals who are not authorized to receive it.

In order for us to send you unsecured emails containing your health information, please consent by signing on the signature line below. We will continue to use secure, encrypted email as much as possible.

I understand the risks associated with use of regular, unsecured email to transmit my PHI to me or to others I have designated to receive my PHI. By signing below, I consent to the use of unsecured email by Key Autism Services.

_____ _____

Parent/Caregiver Signature Date

_____

Printed Name

Financial Responsibility

We are committed to assisting our clients and families to understand their insurance coverage and financial responsibilities related to ABA treatment. If you have any questions regarding your insurance coverage or financial responsibly, please contact operations support @ support@keyautismservices.com

Your Insurance or Other Program Benefits

- Prior to your initial evaluation, Key Autism Services will contact your insurance company to verify insurance coverage and benefits eligibility.
- For insurance funded services, KAS will coordinate with your insurance company to obtain authorization for services.
- Services will not be rendered until authorization for services has been approved by the insurance company.

Your Payment Responsibility

- You are responsible for any deductibles, co-insurance, co-payments, or non-covered services associated with treatment. Invoices will be e-mailed monthly and payment is due upon receipt. If you are unable to provide payment for the invoice, please contact support@keyautismservices.com to arrange a payment plan.
- Any insurance changes (policy changes, member identification number changes, etc.) must be communicated in advance to prevent a disruption of services. If your insurance coverage changes or is terminated and we are not able to receive payment retroactively, you are responsible for any non-covered services.
- If Medicaid is your secondary provider and services not covered, you will be notified. You will be responsible for any deductibles, co-payments and co-insurance fees. You can decide at that time to continue or terminate services.
- KAS accepts checks, money orders, and all major credit cards for payment of services. Checks returned for insufficient funds will be assessed a $35 returned check fee.

Billing for Indirect Care (non face to face services)

Your child's treatment program may require that indirect care be conducted. These indirect care activities may include, but are not limited to; program creation, report writing, development of stimuli. The Explanation of Benefits (EOB) received from your provider may reflect dates of services where you did not receive any face to face direct treatment services. These dates are reflective of these indirect services.

Suspension/Discharge from Services

KAS reserves the right to suspend or discharge ABA services for failure to receive payment for outstanding balances.

Financial Responsibility: I understand that Key Autism Services will make all reasonable attempts to bill my insurance company first, and will work with me to address potential problems. However, in the event that my insurance company does not pay for any portion of services provided, I agree and acknowledge that I am responsible for any fees remaining.

Authorization to Release Information: I authorize Key Autism Services, to release information requested by my insurance company to complete my claim.

Authorization to Pay Claims to Key Autism Services: I authorize payment from the insurance company to be directly sent to Key Autism Services. This allows Key Autism Services to file claims on my behalf.

_____ _____

Parent/Caregiver Signature Date

_____

Printed Name

Consent for ABA Services

Applied Behavior Analysis (ABA) is an evidenced-based, scientific approach used to improve socially significant behaviors. Key Autism Services employs the procedures of ABA to consumers in home and community settings. By consenting to ABA services, you consent that Key Autism Services has the right to :

- Provide home and/or community-based ABA services
- Develop treatment plans, goals, and objectives
- Collect data to report progress on goals and objectives
- Discuss treatment with insurance providers for authorization purposes
- Create programs and materials for treatment
- Edit treatment plan and behavior plan goals or procedures

Consent for the following will be received separately, if needed:

- Functional Behavioral Assessment (FBA)
- Functional Analysis (FA)
- Submission of treatment plans to insurance companies
- Implementation of behavior plans

I consent for my child to receive the ABA treatment as outlined above from onset of insurance authorization to termination of ABA services.

_____ _____

Parent/Caregiver Signature Date

_____

Printed Name

_____

Client Name

Client Information

Client Name: _____
Address:_____
City:_____State:_____Zip:_____
DOB:_____Gender: _____

Primary Contact Name: _____
Relation to Client: _____
Phone:_____Best time(s) to Contact? _____
Email: _____

Secondary Contact Name: _____
Relation to Client: _____
Phone:_____Best time(s) to Contact? _____
Email: _____

Primary Insurance Provider: _____
Phone Number: _____
Member ID:_____Group #: _____
Insured Name:_____Insured DOB: _____
Insured SSN: _____

Secondary Insurance Provider: _____
Phone Number: _____
Member ID:_____Group #: _____
Insured Name:_____Insured DOB: _____
Insured SSN: _____

Emergency Contact Name: _____
Relation to client: _____
Emergency Contact Phone: _____

Initial Risk Assessment (For Intake Purposes Only)

Client Name: _____ Reporting Party: _____

Please answer if the following has occurred in the past two years. If the answer is yes, please describe the incident in detail.

1. Has the parent/caregiver, or any other person had to use physical restraint on the client at any time during the past two years? If Yes, please describe the incident(s)_____
   _____
   _____

2. Has the client engaged in dangerous physical behavior (e.g., destroyed property; harmed or threatened harm to another individual; or engaged in, or threatened to engage in, self-harm) at any time during the past [two] years? If yes, please describe the last incident.
   _____
   _____
   _____

3. Has the client had or made suicidal or homicidal thoughts, comments, or attempts?
   _____
   _____
   _____

4. Has mobile crisis or the police intervened for incidents of challenging behavior? If the answer is yes, how many time have the police intervened during that period? Please describe the last incident that led to police intervention.
   _____
   _____
   _____

5. Has the child received a safety evaluation?
   _____
   _____

6. Has the client been hospitalized in a psychiatric setting? When was the most recent hospitalization? Please describe the incident that led to the most recent hospitalization.
   _____
   _____

7. Has the client engaged in aerophagia (repetitive air swallowing), rumination (vomiting and eating partially digested food), pica (eating items that are not food)?
   _____
   _____
   _____

_____ _____

Parent/Caregiver Signature Date

Coordination of Care

Fill in the information for care providers you would like us to collaborate with for the care of the patient

Pediatrician: _____

Address: _____

Phone:_____Email: _____

School Social Worker: _____

Address: _____

Phone:_____Email: _____

Psychologist: _____

Address: _____

Phone:_____Email: _____

Neurologist: _____

Address: _____

Phone:_____Email: _____

Occupational Therapist: _____

Address: _____

Phone:_____Email: _____

Speech Therapist: _____

Address: _____

Phone:_____Email: _____

Physical Therapist: _____

Address: _____

Phone:_____Email: _____

Authorization for Release of Medical Records *and Medical Information*

Client Name:_____Date of Birth: _____

Address: _____

I hereby authorize and consent Key Autism Services to release my medical records and medical information, whether in <u>oral, written or electronic form</u>, relating to the medical services provided for the purposes of coordination of care activities to the recipient listed below:

Name:_____

Title:_____

Relation to Client: _____

Address: _____

Phone Number:_____ Fax Number: _____

Email: _____

Restrictions:

_____

_____

_____

This authorization is valid for a period of_____(months/years) from the date signed.

Signature:_____ Date: _____

Printed Name:_____ Relation to Client: _____

Parent/Caregiver Signature Page- Parent Handbook

I have read, understand, and have had an opportunity to ask questions about the policies and procedures included in the Key Autism Services' Parent Handbook. I will adhere to the policies and procedures outlined in the Parent Handbook.

_____ _____

Parent/Caregiver Signature Date

_____

Printed Name

_____

Client Name

Telemedicine Member Consent Form

PATIENT NAME:

DATE OF BIRTH:

1. **PURPOSE**: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s): ABA Services for children and families diagnosed with Autism

2. **NATURE OF TELEMEDICINE CONSULT**: During the telemedicine consultation:

    a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
    b. A physical examination of you may take place.
    c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.

3. **MEDICAL INFORMATION & RECORDS**: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.

4. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and state law apply to information disclosed during this telemedicine consultation.

5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **DISPUTES**: You agree that any dispute arriving from the telemedicine consult will be resolved in New Jersey, and that New Jersey law shall apply to all disputes.

7. **RISKS, CONSEQUENCES & BENEFITS**: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telemedicine consultation for the procedure(s) described above.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

ABA Treatment Expectations

ABA is an evidenced-based, scientific approach used to improve socially significant behavior. The strategies and practices used to elicit this behavior change may pose potential risks and may result in potential benefits to your child.

Possible Risks Associated with ABA Therapy

1. Disruptions to routine as a result of the time requirement involved in a direct service schedule and parent training expectations
2. Slow or inconsistent progress and lack of generalization as a result of caregiver involvement, lack of coordination of care with other providers, or prior history of reinforcement of undesirable behaviors.
3. Stress on family unit while observing and anticipating behavior change.
4. Some components of ABA therapy involve “extinction” which may result in short term increase of challenging behavior before decreasing.

Possible Benefits Associated with ABA Therapy

1. Decrease undesirable behaviors
2. Increased social, communication, and play skills
3. Independence with activities of daily living including toileting, dressing, and community-based skills.
4. Reduced need for ABA Therapy