2800 Scenic Dr, Ste 12
Blue Ridge, GA 30513
706-946-0466 (office)
888-974-1438 (secure fax)
info@BlueSkiesABA.com

ABA Program Intake Packet

Thank you for selecting Blue Skies ABA, Inc. to help meet the needs of your child.

This packet will help inform you about our policies and procedures and details the documents and information required prior to your intake appointment.

Thank you for the trust that you are placing in us to assist you and your family. We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information that we have the better able we will be to assist you and your family. If at any time in this process you have any questions, please contact us.

We look forward to meeting you and your child,

Debbie Hodgdon, CEO, MEd, BCBA

706-946-0466 (office)

Required Steps to Begin ABA Services:

1. Intake Packet:
    a. All pages must be filled out in their entirety
    b. All signature pages must be signed and dated
2. Documentation Requirements-Provided to Blue Skies ABA. Inc.:
    a. Diagnostic Assessment Report by Psychologist, Psychiatrist or Doctor with required credentials to complete the assessment. Most insurers require standardized tests (such as Autism Diagnostic Observation Scale, Autism Diagnostic Interview, or Childhood Autism Rating Scale to establish a diagnosis of Autism Spectrum Disorder. In Georgia, insurers will only pay for ABA for children with autism. Georgia Medicaid requires specific testing, please refer to Assessment Guidelines for Georgia Medicaid on the next page.
    b. Letter of Medical Necessity/Medical Referral from pediatrician or diagnosing physician for Applied Behavior Analysis. Insurers require the referral to also list the diagnosis code for autism (F84.0) and must be signed.
    c. Authorization to Release Information filled out with all current and previous providers/ schools, signed and dated.
    d. Copy of the child's current IEP (if applicable)
3. Insurance prior authorization for initial assessment request submitted by Blue Skies ABA, Inc. to all insurance companies for client.
4. Insurance prior authorization approval for initial assessment is received from all insurance companies by Blue Skies ABA, Inc.
5. Intake Assessment with Blue Skies ABA BCBA
    a. Parent Interview
    b. Natural Observation of Client – at least one home or center-based observation session –all parents/guardians must be present.
    c. Functional Assessment of Behavior and ABLLS-R™ or VB-MAPP completed by BCBA.
    d. Meeting with case manager to review treatment goals and program plan.
6. Blue Skies ABA, Inc. completes and submits treatment plan and prior authorization request for ongoing services to all insurance companies for client.
7. Insurance prior authorization approval for ongoing services is received from all insurance companies by Blue Skies ABA, Inc.
8. Arrangement of schedule between therapists and client for ongoing services.

Assessment Guidelines for Georgia Medicaid

Georgia Medicaid Requirements for Prior Approval for Applied Behavior Analysis (ABA)

Prior Authorization (PA) is required for all Medicaid-covered ABA. Services without a PA will not be covered.

All ABA PAs must be requested directly from the ABA provider or clinic where services will be rendered.

A documented diagnosis of ASD must be established by a licensed physician or psychologist, or other licensed professional as designated by the Medical Composite Board prior to completing a PA for Behavioral Assessment or Treatment Services. The diagnostic evaluation must use valid and reliable evaluation tools that conform to industry standards and include direct observation, parent/caregiver interviews, and standardized tools for the diagnosis of autism.

The evaluation must include the following:

- **Minimum of two (2) assessment tools (1 clinician observational assessment, 1 caregiver assessment)**
- **Summary of each individual assessment.**
- **Include the date it was completed and include the tests administered with scores.**
- **Include the evaluators name and credentials.**

In general, two measures are required as multi-modal, multi-informant assessments are empirically supported. The following tools were selected due to meeting the following criteria:

- Standardized assessment tools specifically utilized to assess ASD or the specific core characteristics present in individuals with ASD
- Robust empirical support for the individual's age
- Includes diagnostic validity and reliability for this purpose

The following chart lists all accepted diagnostic assessments for both the clinician observational assessment and caregiver assessment.

Primary Clinician Tool	Other tools needed:
ADOS2 (Autism Diagnostic Observation Schedule) 12 months through adulthood	Parent input via formal tool (screener, rating scale, or clinical interview)
GARS-3 (by clinician) (Gilliam Autism Rating Scale) 3 - 22 years	Parent input via formal tool (screener, rating scale, or clinical interview)
CARS2 ST/HF (Childhood Autism Rating Scale) 2 years and up	Parent input via formal tool (screener, rating scale, or clinical interview)
STAT (Screening Tool for Autism in Toddlers and Young Children) 24 – 35 months	Parent input via formal tool (screener, rating scale, or clinical interview)
CSBS (Communication and Symbolic Behavior Scales) 6-24 months	Parent input via formal tool (screener, rating scale, or clinical interview)
TELE-ASD-PEDS Children under 3 years	Parent input via formal tool (screener, rating scale, or clinical interview)
NODA (Naturalistic Observational Diagnostic Assessment) 18 months – 6 years	Parent input via formal tool (screener, rating scale, or clinical interview)
DISCO (Diagnostic Interview for Social and Communication Disorders) any age	Parent input via formal tool (screener, rating scale, or clinical interview) – the DISCO can be used as a parent interview and/or clinical observation tool
Rapid Interactive Screening Test for Autism in Toddlers (RITA-T) 18 – 36 months	Parent input via formal tool (screener, rating scale, or clinical interview)
Autism Detection in Early Childhood (ADEC) children under 3 years	Parent input via formal tool (screener, rating scale, or clinical interview)
Caregiver Tool	
Accepted ASD specific Caregiver tools:	
ADI-R (Autism Diagnostic Interview) 2 years and up	Primary Clinician tool
DISCO (Diagnostic Interview for Social and Communication Disorders) any age	Primary Clinician tool
CARS QPC (Childhood Autism Rating Scale – Parent Questionnaire) 2 years and up	Primary Clinician tool (other than CARS)
GARS-3 (Gilliam Autism Rating Scale) 3 – 22 years	Primary Clinician tool (other than GARS)

SCQ (Social Communication Questionnaire) 4 years and up	Primary Clinician tool
MCHAT (Modified Checklist for Autism in Toddlers) 16-30 months	Primary Clinician tool
SRS-2 (Social Responsiveness Scale) 2.5 and up	Primary Clinician tool
ASRS (Autism Spectrum Rating Scale) 2 – 18 years	Primary Clinician tool
Autism Behavior Checklist (ABC) 3 years and older	Primary Clinician tool
Accepted Non-ASD specific Caregiver tools:	**These can be used as a parent/caregiver assessment**
BASC (Behavior Assessment System for Children) 2 – 21 years, 11 months	Primary Clinician tool
PDD-BI (PDD-Behavior Inventory) 18 months – 18 years, 5 months	Primary Clinician tool
PEDS:DM (Parents' Evaluation of Developmental Status) birth – 7 years, 11 months	Primary Clinician tool
ASQ-3 (Ages and Stages Questionnaire) 1 - 66 months	Primary Clinician tool
ASQ:SE2 (Ages and Stages Questionnaire: Social Emotional) 6 – 60 months	Primary Clinician tool
CBRS (Conners Behavior Rating Scale) 6 – 18 years	Primary Clinician tool
CDI (Child Development Inventory) 0-6 years	Primary Clinician tool
CSBS DP Infant-Toddler Checklist 6-24 months	Primary Clinician tool

A diagnostic re-evaluation to re-confirm diagnosis may be required if any of the following is indicated in the request.

- Provisional diagnosis of Autism Spectrum Disorders (as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders).
- No formal neuropsychological evaluation was completed/conducted.
- More than 5 years from initial diagnosis and no evidence of ongoing assessment and treatment.
- The re-evaluation must include, at a minimum, 1 clinician observational assessment.

School psychoeducational assessments are not acceptable for diagnostic evaluations.

Approach to Clinic ABA/VBA

- Our approach to working with each child is:
    - Positive
    - Focuses on skills building
    - Is individually tailored to meet each child's unique needs
    - Focuses on keeping children motivated to learn
    - Utilizes the best research supported approach
- The curriculum addresses the major issues common in autism, and identified by the National Academy of Sciences as essential:
    - Understanding and using language
    - Building broader social skills
    - Communicating with and relating to peers
    - Building age appropriate and symbolic play skills
    - Increasing conceptual thinking and cognitive skills

Blue Skies ABA's trained therapists work one-on-one with each child closely monitoring responses to match the difficulty of the material and method of instruction to the child's ability level and rate of learning. All of our therapists hold at least a bachelor's degree or have equivalent extensive training specifically in research supported treatments for autism spectrum disorders. Supervision of each child's program is provided by one of our BCBAs with regular progress reviews monthly. In addition, parent training, programs to address problem behaviors and a range of behavior analytic services are offered through our clinic services program. Our focus is on helping your child gain skills in language and social areas using state-of-the-art behavioral interventions. We provide behavioral assessments, parent & staff training, program supervision, and quality monitoring for ABA/Verbal Behavior Analysis clinic programs. Each of our program supervisors are board certified by the Behavior Analysis Certification Board™. Please contact our office for further information or clarification.

Financial Information

We are currently authorized to accept insurance payments from Medicaid, Medicaid CMOs-Amerigroup, PeachState & CareSource, Blue Cross/Blue Shield, Humana, and Aetna. Insurance plans coverage of ABA services vary, and prior to services being initiated verification that your plan provides coverage of ABA services is required. If we do not currently accept your insurance, we may be able to apply for a single case agreement. Private pay is also available if a potential client does not have insurance or we are unable to obtain a single case agreement.

Scheduling and Sessions

A Board Certified Behavior Analyst oversees all cases and is the primary contact for your child's case.

Sessions for ABA services are usually scheduled in 2-3-hour blocks. The research is clear that longer sessions result in greater retention and this makes scheduling more convenient for all parties. If this is not convenient for your family, please bring this up during at the intake meeting.

A parent or legal guardian is required to be present and available in the home or clinic throughout the therapy session(s).

Refer to our cancellation policy and financial responsibility forms for more detailed information. Insurance carriers are not responsible for missed appointment fees.

The universal standard for therapy, be it the insurance standards or the professional standards of various organizations like the APA, ASHA, etc., is that a therapy: "hour" is 45-50 minutes of direct contact with the patient with the remaining 10-15 minutes devoted to required record keeping and other administrative requirements. Typically, for a 3-hour therapy session, our staff take ~10 minutes to arrange the materials prior to commencing direct therapy with the child and ~ 15 minutes at the end to record data, tidy the setting, and discuss the session with the parent.

The standard of care outlined in the ABA International's Revised Guidelines for Consumers of Applied Behavior Analysis Services to Individuals with Autism includes supervision of therapists on an ongoing basis, program consultation, program review, and program revision as services performed by a BCBA. These services are necessary for a program to meet minimum professional standards and are not optional.

CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

Confidential

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information, which you think, may be helpful understanding your child. Blue Skies ABA, Inc. considers all information provided by you as strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information.

PLEASE PRINT

Name of Person Completing this form: _____

Legal Name of Child/Adolescent: _____

Nickname or name child routinely goes by: _____

Child's Date of Birth: _____ Age: _____Social Security #:_____

Home Address: _____
Street

_____ _____ _____ _____
City County State Zip

Email Address:_____

Home Phone Number: _____

Work Phone Mother:_____ Cell Phone Mother: _____

Work Phone Father: _____ Cell Phone Father: _____

School Name:_____System: _____Grade: _____

School Telephone Number: _____

Current Teacher(s): _____

Who referred you to our practice? _____

Please describe the problems your child is now having, and what type of services you are seeking from us for these problems. Please use the back of this page for additional space.

_____

_____

_____

_

PARENT/GUARDIANS LIVING IN THE HOME:

Marital Status (Select from Drop Down): Marital Status

- If divorced, who has physical custody? _____ Is it full or joint?_____
- Who has legal custody? _____ Is it full or joint? _____

If divorced, please provide a copy of the custody agreement.

Mother's Name _____

Date of Birth: _____ Age: _____

Occupation: _____ SSN:_____

Employer: _____ Email:_____

Education Completed _____ Health: Health

Does either parent's job require him/her to be away from home long hours or extended periods? (circle): Yes/No

Father's Name _____

Date of Birth: _____ Age: _____

Occupation: _____ SSN:_____

Employer: _____ Email:_____

Education Completed _____ Health: Health

Does either parent's job require him/her to be away from home long hours or extended periods? (check): ☐ Yes ☐ No

Siblings:

Name	Age	Relationship	Living with	School	Grade
			☐ Y/N ☐		
			☐ Y/N ☐		
			☐ Y/N ☐		
			☐ Y/N ☐		
			☐ Y/N ☐		
			☐ Y/N ☐		

Please list additional sibling in the above format on the back of this page.

Insurance Information

Primary Insurance Company: _____

Subscriber/Policyholder Full Name: _____

Relationship to child: _____

Insurance ID: _____

Policy #: _____

Subscriber/Policyholder Date of Birth: _____

Secondary Insurance Company: _____

Subscriber/Policyholder Full Name: _____

Relationship to child: _____

Insurance ID: _____

Policy #: _____

Subscriber/Policyholder Date of Birth: _____

Tertiary Insurance Company: _____

Subscriber/Policyholder Full Name: _____

Relationship to child: _____

Insurance ID: _____

Policy #: _____

Subscriber/Policyholder Date of Birth: _____

Please attach front and back copies of insurance cards so that we may call your insurer to determine benefits and get approval to start services.

PSYCHOLOGICAL HISTORY:

Is there a history in your immediate or in the mother's or father's extended family, of the following and if so who?

Yes	No	Condition	Who (Relationship to Child)
☐	☐	Autism Spectrum Disorders	
☐	☐	Learning Problems/Disabilities	
☐	☐	ADHD-ADD-Attention Problems	
☐	☐	Depression or Bipolar Disorder	
☐	☐	Anxiety / Panic attacks	
☐	☐	Obsessive Compulsive Disorder / Phobias	
☐	☐	Intellectual Disability	
☐	☐	Psychosis or Schizophrenia	
☐	☐	Substance Abuse or Dependence	
☐	☐	Other Mental Health Concern (Please list)	

Has the child you are seeking services for been evaluated in the past? ☐ Yes ☐ No
If Yes, please list the following Information on the previous evaluation(s)

Diagnosis	Type of Assessment	Date of Assessment	Assessor Name & Credentials	Copy Available
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

Has your child been diagnosed with an Autism Spectrum Disorder? (circle) ☐ Yes ☐ No
Diagnosis Code:_____ Severity Level:_____

Assessor Name and Credentials:_____ Date:_____

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child:

_____

_____

_____

PRE-NATAL AND DELIVERY HISTORY:

Were there any complications with the pregnancy? ☐ Y ☐ N
If **yes**, please describe below including treatment details:

_____

_____

_____

Was birth at Full Term? ☐ Y ☐ N If **no**, please provide details:

_____

_____

Type of Delivery: (check) ☐ Spontaneous/Induced ☐ Vaginal/C-Section

Complications? ☐ Y ☐ N If **yes**, Please provide details:

_____

_____

Birth Weight: _____lbs _____oz Apgar Scores: _____

Concerns at Birth? ☐ Y ☐ N If **yes**, please provide detail including any treatments given:

_____

_____

_____

Is there any additional pre-natal or birth information that might be of assistance to us?

_____

_____

_____

DEVELOPMENTAL HISTORY:

1. Please indicate the age at which your child did the following:

_____ Rolled over consistently

_____ Sat up unsupported

_____ Crawled

_____ Walked Unassisted

_____ Stood

_____ Said 1st Word Intelligible to strangers

_____ Said 2-3 word phrases

_____ Used Sentences regularly

_____ Toilet trained during the day

_____ Dry through the night

_____ Dressed Self (without fastenings)

2. Please indicate if your child is experiencing any of the following: (check all that apply)

☐ Problems with eating

☐ Bed Wetting /Soiling

☐ Isolated socially from peers

☐ Problems with authority

☐ Problems making friends

☐ Anxiety

☐ Problems keeping friends

☐ Unmotivated

☐ Problems getting to sleep

☐ School concentration difficulties

☐ Problems controlling temper

☐ Grades dropping or consistently low

☐ Nightmares

☐ Sadness or Depression

3. List any operation, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had: _____

_____

_____

_____

4. List current and previous medication in the grid below (use back of page for additional):

Medication	Dosage	Currently Taking Y/N	Reason for Taking

5. Child's current height: _____Ft. _____Inches Weight: _____Lbs.

6. With which hand does the child write: _____

7. Does the child have any vision problems? _____

Please list date of last vision test and who performed (pediatrician, optometrist, School)

_____

_____

8. Does the child have any hearing problems? Please list date of last hearing test and who performed (pediatrician, audiologist, school): _____

_____

9. Name of child's pedicatrician:_____

Practice name: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Please list information on additional physicians on the back of the page

EDUCATION HISTORY:

1. List in chronological order all schools your child has attended:

Name	System	Years	Grade	Gen Ed, Self Contained, 1:1 Aide

2. Name(s) of current teacher(s) _____

3. Does your child's teacher have concerns about him/her (list)

_____

4. What is your child's favorite subject/class? _____

5. What is your child's least preferred subject/class? _____

6. Has your child ever repeated a grade? Y/N If yes, what grade(s)?: _____

7. If your child has been in Special Education, did they have a: (please check all that apply)

- ☐ 504 Plan
- ☐ I.E.P.
- ☐ Psychological Evaluation
- ☐ Special Evaluation
- ☐ Behavior Intervention Plan
- ☐ Occupational Therapy Evaluation
- ☐ Physical Therapy Evaluation
- ☐ Adaptive Technology Evaluation

8. If your child has been in Special Education, how were they served? (please check all that apply)

- ☐ Consultation
- ☐ Collaborative Education
- ☐ Pull Out
- ☐ Special Program
- ☐ Resource Classroom
- ☐ Team Taught Classes
- ☐ Self-Contained Classroom
- ☐ Psycho educational Center

9. Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

☐ Football	☐ Karate	☐ Dance (type) _____
☐ Baseball	☐ Piano	☐ Music (type) _____
☐ Cheerleading	☐ Scouts	☐ Gymnastics (type) _____
☐ Basketball	☐ Soccer	☐ Other(s): _____

10. List any special abilities, skills, strengths your child has:

_____

_____

_____

_____

_____ _____

DISCIPLINE INFORMATION:

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed:

	Intervention	**How likely are you to USE it**						**How likely is it to WORK**				
		1= Very Likely				**5**= Unlikely		1= Very Likely				5= Unlikely
		1	2	3	4	5		1	2	3	4	5
☐	Let situation go											
☐	Take a privilege away (ex. No TV)											
☐	Assign an additional chore											
☐	Take away something material											
☐	Send to room											
☐	Physical punishment											
☐	Reason with child											
☐	Ground child											
☐	Yell at child											
☐	Send to timeout											
☐	Other:											

**Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Please circle the LEAST effective.

Please rate what percentage of discipline is handled by each of the following:

Father:_____% Mother:____% Other: _____% (Please Specify:)_____

GENERAL INFORMATION:

Please list the **five** things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sister, etc.

	Like Child to do More Often	Like Child to do Less Often
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Therapeutic Services:

Please list all types of therapy your child receives: physical, occupational, speech, etc.

Therapy Type	Frequency	Provider

Availability

Please list the times below that your child is occupied with school or other therapies.
Fill in a Y in each box the applies:

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
9-10 am							
10-11 am							
11 am-12 pm							
12-1 pm							
1-2 pm							
2-3 pm							
3-4 pm							
4-5 pm							
5-6 pm							
6-7 pm							

Are you willing to pull your child out of school for appointments to receive Applied Behavior Analysis therapy? ☐ Yes ☐ No

INFORMED CONSENT FOR BEHAVIORAL SERVICES:

I hereby voluntarily apply for and consent to services by Blue Skies ABA, Inc. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below: (1) where abuse or harmful neglect or children, the elderly, or disabled or incompetent individual is known or reasonably suspected: (2) where such information is necessary for the company to pursue payment for services rendered; (3) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the therapist; (4)where the client is examined pursuant to a court order. I hold Blue Skies ABA, Inc. harmless for releasing information under the above conditions.

_____ _____

Signature Date

_____ _____

Printed Name Name of Client

Cancellation Policy:

Blue Skies ABA's goal is to provide quality and consistent care to all of our families and employees. In order for us to be able to continue to provide this level of service as well as retain quality employees we have adopted a strict cancellation policy. We understand that emergencies and illness do occur without notice and will excuse these absences on a case-by-case basis. It is our goal to be able to assist your family in maintaining your child's goals with consistent services. If proper notice is not received over several occasions services will be put on hold as to allow for other families needing services to be assisted and for the maintenance of consistent staffing schedules. The BCBA on the case will speak with the family to discuss a schedule that the family can maintain without incurring more unexcused absences.

In order to maintain clinical goals creating continued client success, Blue Skies ABA reviews client's case very carefully. If cancellations exceed 20% of scheduled services for 2 consecutive months, the BCBA on your family's case will review the progress or decline of the client and decide which service model will allow for the continued decrease in appointments attended. Services at any time can be placed on hold entirely or families can be switched to a parent training model with no one to one client client/staff appointments.

24 Hours Notice:

Blue Skies ABA requires at minimum 24 hours notice for cancellation of an individual date of service. Notice is required in **BOTH written and verbal form. Written form is accepted via email to deb@blueskiesaba.com. Verbal form should be provided to staff working with the client on the date of service affected.**

Extended Leave Notice:

Blue Skies ABA requires at **minimum 30 days notice** for cancellation of 2 or more consecutive dates of services being missed. Notice is required in **BOTH written and verbal form. Written form is accepted via email to deb@blueskiesaba.com. Verbal form should be provided to staff working with the client on the date of service affected.**

At the Door Cancellation:

If a family receives in home services and cancels when staff arrives or is not home at scheduled appointment time this will be considered an at the door cancellation. This will result in an immediate pause in services and prompt a meeting with the BCBA on the case to resume services.*

Late to Appointment:

We understand that sometimes unforeseen circumstances may arise, causing you to arrive late to your appointment. Any client who arrives more than 1 hour late will be treated as a no show and appointment will be canceled. Refer to fee schedule below for description of fees associated with late and no show appointments. Blue Skies ABA has the right to pause services and a meeting will be scheduled with the BCBA to discuss therapy schedule.

No Show:

If a family does not attend an in-clinic appointment without notice this will be considered a no show. This will result in an immediate pause in services and prompt a meeting with the BCBA on the case to resume services.*

*BCBA meeting will be held at the earliest convenience of the BCBA on the client's case. The BCBA will evaluate progress or decline of the client and meet with the family to create a new schedule more maintainable to the change in a family's attendance. Options could include reduction in services or complete removal of client services changing to a parent model.

Fees*:

All fees incurred must be paid IN FULL at the next appointment attended or if a pause of services has been instated payment is due within 7 days of missed appointment. * Fees are not applicable to clients with Medicaid, but pauses in services and meeting with BCBA's will apply.

a. **Less than 24 hours notice: $50**
b. **Less than 30 days notice for cancellation of 2 or more consecutive days: $50 per day missed**
c. **At the Door Cancellation-In Home Session: $75 and immediate pause in services**
d. **15 minutes late to appointment: $30 fee applies**
e. **30 minutes late to appointment: $60 fee applies**
f. **45 minutes late to appointment: $90 fee applies**
g. **1 hour late to appointment: Appointment canceled and no show fee of $75 applies**
h. **No Show: $75 and immediate pause in services**

Parent/Guardian Signature

Date

Printed Name

Name of Client

Financial Responsibility:

Deductible/Co-Insurance/Co-Payment:

It is the responsibility of the family to contact their insurance company to find out the out of pocket expenses associated with their plan for ABA services. The family can contact members services, phone number will be on the back of the insurance card, and request if the codes listed below are covered and at what cost to the family. Blue Skies ABA will also contact the insurance company to verify information received by family. Although our Billing Department will verify this information it is still required for the family to contact and have a full understanding of all costs associated with ABA services.

Codes: 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158

Notice of Insurance Change:

Insurance changes and yearly insurance renewals are the responsibility of the family to inform Blue Skies ABA prior to the change going into effect. **Notice is required 30 days prior to the change going into effect**. Many insurance carriers **require** an authorization prior to services being rendered. A pause in services can be applied during the process of acquiring the authorization if authorization as most insurances do not allow for an authorization request prior to the start of the new plan. Services can continue at client request with the understanding services rendered are billed at the current rates of Blue Skies ABA's fee schedule. **In the case that Blue Skies ABA is not informed prior to the change of insurance, ALL SERVICES RENDERED WILL BE THE FULL FINANCIAL RESPONSIBILITY OF THE FAMILY BASED ON THE CURRENT FEE SCHEDULE RATES.** Blue Skies ABA's fee schedule is available upon request.

Monthly Invoices:

Itemized invoices are emailed at the beginning of each month, mailed upon request, for services rendered with a remaining balance due to family. All invoices have a due date listed and payment is due in full by that date as to not incur late fees (see below).

Payments:

Please make checks payable to Blue Skies ABA, Inc.

Late Payments:

Payments made late will have the following fees applied as well as possible termination of services till payment has been received:

a. 30 days past due: $25
b. 60 days past due: $50
c. 90 days past due: $75
d. 120 days past due: $100

Fees:

All fees incurred must be paid IN FULL at the next appointment attended or if a pause of services has been instated payment is due within 7 days of missed appointment. * Fees are not applicable to clients with Medicaid, but pauses in services and meeting with BCBA's will apply.

a. Less than 24 hours notice: $50
b. Less than 30 days notice for cancellation of 2 or more consecutive days: $50 per day missed
c. At the Door Cancellation-In Home Session: $75 and immediate pause in services
d. 15 minutes late to appointment: $30 fee applies
e. 30 minutes late to appointment: $60 fee applies
f. 45 minutes late to appointment: $90 fee applies
g. 1 hour late to appointment: Appointment canceled and no show fee of $75 applies
h. No Show: $75 and immediate pause in services

_____ _____

Parent/Guardian Signature Date

_____ _____

Printed Name Name of Client

Service Agreement and Consent Form

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

SERVICES OFFERED We will provide services specifically designed to help you (and/or your minor child), or otherwise provide you with referrals to other professionals. Our behavioral services consist primarily of individual assessments (behavioral evaluations), training, center based, in-home and in-school consultations and observations, long-term ABA service provision to youth on the autism spectrum, and short-term consultations with individuals, parents, educators, and other related professionals.

APPOINTMENTS Except for rare emergencies, we will see you (or your child) at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitate the occasional cancellation of appointments. Please refer to the Cancellation Policy included for detailed information on this policy.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

Services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions and as mandated by Alaska and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

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

PROFESSIONAL CONSULTATIONS Behavior Analysts routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them. We will tell clients about these consultations. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

FEES All services rendered are filed with your insurance company. You are responsible for all deductibles, co-payments, and coinsurance.

PROFESSIONAL RECORDS You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in one set of professional records. The Clinical Record includes information about reasons for seeking our professional services; the impact of any current or ongoing problems or concerns; assessment, consultative, or therapeutic goals; progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Personal notes are taken during supervision sessions and by the ABA tutor. While the contents of personal notes vary from client to client, most are antidotal notes related to progress and future goals, reference to conversations, and hypotheses of the professional. These Personal Notes are kept separate from the Clinical Record are not available to you and cannot be sent to anyone else, including the insurance company. Your signature below waives all rights, now and in the future, to accessing these records in any form under any circumstances. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it

PATIENT RIGHTS HIPAA provides you with several rights regarding your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

CONTACTING US Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours except for holidays and weekends.). If you are difficult to reach, please provide your availability and how best to contact you in return. Due of the nature of the services we provide, we do not provide on-call coverage 24 hours per day, 7 days a week. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

CONSENT: Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

Client or Child's name	**Date**
Parent/Guardian #1 name	**Parent/Guardian #2 name**
Parent/Guardian #1 signature	**Parent/Guardian #2 signature**