ABC of NC

Client Registration

Client Information

Last Name:		First Name:		Middle Name:
Date of Birth:	Sex/Gender:	Preferred Name:		
Race/Ethnicity:		Primary Language:		

Child lives with: *please provide formal documentation of custody/guardianship to ABC of NC

☐ Both biological parents ☐ Joint custody (2 homes)* ☐ One biological parent**(specify):*__________

☐ One biological parent and stepparent**(specify):*_____________ ☐ Relatives*(*specify):*____________

☐ Adoptive parent(s)* ☐ Foster parent(s)* ☐ Other* *(specify):*________________

Street Address:			
City:	State:	Zip:	County:

Referral purpose: ☐ Diagnostic evaluation for ASD ☐ Seeking treatment for ASD ☐School ☐Other

Who referred you to ABC of NC?

Parent/Guardian (A) Information- Is this person the legal guardian? ☐ Yes ☐ No

Last Name:		First Name:		Middle Name:
Date of Birth:	Sex/Gender:	Race/Ethnicity:		Preferred Name:
Relationship to Client:		Primary Language:		
Street Address:				
City:		State:	Zip:	County:
Email Address:				
Home Phone:		Cell Phone:		Business Phone:

Parent/Guardian (B) Information- Is this person the legal guardian? ☐ Yes ☐ No

Last Name:		First Name:		Middle Name:
Date of Birth:	Sex/Gender:	Race/Ethnicity:		Preferred Name:
Relationship to client:		Primary Language:		
Street Address:				
City:		State:	Zip:	County:
Email Address:				
Home Phone:		Cell Phone:		Business Phone:

Person Financially Responsible (Guarantor)

Is person financially responsible same as Guardian A or Guardian B? If yes, then skip to next section.	Yes No
Person Responsible for Account:	Relationship to client:

Street Address:			
City:	State:	Zip:	County:
Date of Birth:	Sex/Gender:		Power of Attorney:
Employer:			Work Phone:

Insurance Information

Effective Date:	ID#:
Name of Insurance Company:	Group #:
Name of Insured (subscriber):	Relationship to client:
Insured Street Address:	

City:	State:	Zip:
Cell Phone #:	Date of Birth:	Social Security #:
Name of Employer:		Work Phone #:
Do you have additional insurance? YES NO If yes, we will need a copy of the card.		

Authorization for the Release of Medical Information and Assignment of Benefits

I authorize the release of my medical record from The ABC of NC Child Development Center in order to process any claims. I hereby authorize payment directly to ABC of NC Child Development Center for mental health benefits entitled under my insurance plans. I understand that, as the client (or the client's legal parent/guardian), I am responsible for full payment. I understand fees for visits or evaluation services are payable at the time of service unless covered by insurance or arrangements have been made in advance.

____ ____________________

Client Date of birth

____ ____________________

Signature of Client of Legally Responsible Person Date

____ ____________________

Witness Date

	Self	Mother	Father	Sibling (indicate which sibling)	Maternal extended family (Aunt, uncle, grandparent, cousin, etc.)	Paternal extended family (Aunt, uncle, grandparent, cousin, etc.)
Autism Spectrum Disorder						
Consistently aggressive, defiant, and oppositional behavior as a child						
Attention Deficit Hyperactivity Disorder (ADHD) or problems with attention, activity, and impulse control as a child						
Learning disabilities (in math, reading, writing)						
Difficulties in school						
Did not graduate high school						
Speech/language disorder (includes articulation problems)						
Intellectual impairment or developmental delay						
Late to start talking						
Psychosis or schizophrenia						
Depression						
Bipolar or other mood disorder						
Anxiety disorder						
Tics or Tourette's						
Seizures or epilepsy						
Cerebral palsy or other motor difficulty						
Severe visual or hearing impairment						
Substance use disorder						
Arrests						
Abuse, neglect, or exploitation						
Other:						

Parent Marital Status

Are parents:	☐Never married ☐ Married to each other (date:_________________) ☐ Separated* (date: ________________) ☐ Divorced* (date: ________________)
*Custody arrangement if divorced or separated: ______Joint _____Sole (which parent? __________)	
*Please provide formal documentation of custody/guardianship to ABC of NC	

Sibling Information

First Name	Sex/ Gender	Relationship	Birthdate	Is sibling living in same home as client?
	☐M ☐F	☐Full ☐Half ☐Step ☐Foster		
	☐M ☐F	☐Full ☐Half ☐Step ☐Foster		
	☐M ☐F	☐Full ☐Half ☐Step ☐Foster		

Developmental Concerns

How old was your child when you first had concerns with his/her development?	________ months old OR _________ years old	
What were your concerns at that time?		
Did you seek professional help at that time?	Yes	No
If yes, what professionals did you go to and what did that professional say?		
What diagnoses has your child received in the past?		

Client's Developmental and Medical Information

Pregnancy and Delivery

Length of pregnancy (e.g. full term, 40 weeks, 32 weeks, etc.)	Length of delivery (number of hours from initial labor pains to birth):
Mother's age when child was born:	Child's birth weight:
Hospital where child was born:	City and state of birth:

Describe any complications that occurred during pregnancy and delivery: ______________________________

____

Developmental Milestones: Please indicate when your child did the following:

Milestone	*Age*	**Milestone**	*Age*	**Milestone**	*Age*
Rolled over		Smiled		Dressed Self	
Sat without support		Pointed		Crawled	
Pulled to standing		Babbled		Used words daily	
Walked with support		Said words (other than mama and dada)		Combined words into phrases	
Walked independently		Fed self with utensil (spoon, fork)		Started eating solid foods	
Toilet trained: bladder		Toilet trained: bowel		Toilet trained: nighttime	
Dressed self					

Health History: At any time has your child had any of the following:

	Age		*Age*		*Age*

☐ Asthma		☐ Allergies		☐ Chicken pox	
☐ Febrile seizures		☐ Fainting		☐ Measles	
☐ Diabetes, arthritis, other chronic illness		☐ EEG/MRI/CT scan of head/brain		☐ Meningitis and/or encephalitis	
☐ Epilepsy or seizure disorder		☐ Recurrent tonsillitis		☐ Mumps	
☐ Heart or blood pressure problems		☐ Whooping cough (pertussis)		☐ Severe cuts requiring stitches	
☐ High fevers (over 103)		☐ Severe diarrhea/dehydration		☐ Lead poisoning	
☐ Broken bones		☐ Headaches/migraines		☐ Chronic infections (HIV, TB)	
☐ Head injury with loss of consciousness		☐ Genetic/ chromosome studies		☐ Bladder/kidney infection	
☐ Eye or vision problems		☐ Hearing difficulties		☐ Recurrent ear infections	
☐ Surgery		☐ Hospitalization: medical		☐ Hospitalization: behavioral	
☐ Threat/attempt to harm self		☐ Threat/attempt to harm others		☐ Neglect	
☐ Abuse		☐ *12 years or older:* alcohol use concern		☐ *12 years or older:* Drug use concern	

Client's past or current medications:

Medication name & dosage	Date(s) started/discontinued	Reason/effectiveness	Prescribing Physician

Client's allergies including food, medication, environmental, etc. and/or any dietary restrictions:

Allergen/restricted item	Effect(s)/reaction(s)

Client's hospitalizations or serious/recurring illness(es) or injury(ies):

Dates	Age	Hospital	Describe

Client's past or current health/medical services:

Treatment Type	Date(s) started/discontinued	Effect(s)	Physician

Client's past or current biomedical autism treatment(s):

Treatment Type	Date(s) started/discontinued	Effect(s)	Physician/ Provider

Client's past or current supplemental specialized services (e.g., speech language therapy, occupational therapy, etc.):

Treatment Type	Date(s) started/discontinued	Effect(s)	Physician/ Provider

<u>Healthcare Providers:</u>

	Consent to communicate with

Pediatrician: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Primary Care Physician (not pediatrician): Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Psychiatrist: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Psychologist/therapist/counselor: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Dentist: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Surgeon: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Ear, Nose, and Throat provider: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Ophthalmologist/ optometrist: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Occupational Therapist: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Speech Therapist: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Physical Therapist: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Social Worker: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Nutritionist/Dietician: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Early Intervention/ Children's Developmental Services Agency (CDSA) (intervention services before 3 years of age) Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No
Other: Provider/practice locations:	☐Current provider ☐Previous provider	☐Yes * ☐No

*Signed release of information will be needed and kept on file

Client's current childcare/school placement: (please provide copy of current IEP, if applicable)

Name of Childcare Center/School:	Dates of Enrollment:	Grade(s):	Placement (e.g typical, autism, resource, gifted, etc.):
Have you ever been contacted by this childcare center or school concerning any behavioral or developmental concerns? Yes No		If yes, explain:	
Teacher's Name:		Teacher's Email:	
Principal's Name:		School Phone #:	
☐Child not currently enrolled in school. Reason:			

Previous childcare/school experience:

School	Grades attended	City or School District	Special Education, IEP, or 504 Plan

			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

Previous Evaluations: Has your child ever received:

An evaluation for ASD, autism, Asperger's Syndrome, PDD-NOS from a medical doctor, psychologist, or school system?	☐Yes* ☐No	If yes, who did the evaluation: Location: Date:
Developmental, cognitive, IQ, or academic achievement testing?	☐Yes* ☐No	If yes, who did the evaluation: Location: Date:
A behavioral or mental health evaluation (such as for anxiety, ADHD, depression, etc.)	☐Yes* ☐No	If yes, who did the evaluation: Location: Date:
Any other evaluations for another disability or concern?	☐Yes* ☐No	If yes, who did the evaluation: Location: Date:

*If yes, please submit a copy of the report

Social History: Have any of the following stressful events happened within the past 12 months?

☐ Parents/Guardians divorced or separated*	☐ Family financial problem	☐ Death of family pet
☐ Death in the family*	☐ Family accident or illness	☐ Family moved
☐ Parent/guardian changed job or lost job	☐ Change in child care arrangements	☐ Change in schools
☐ Other*:		

*If yes to any above regard change in custody/guardianship, please provide formal documentation

Please describe the most upsetting event that has occurred to your child within the last 12 months:

____

____

Are there any ethnic, cultural or religious traditions, beliefs, or values of which you would like us to be aware?	☐Yes ☐No	If yes, please explain:
Is there any family responsibility structure of which you would like us to be aware? (e.g., financial decision making, disciplinary decision making, etc.)	☐Yes ☐No	If yes, please explain:

Behavior Checklist: Does/ has your child:

Communication/Language				**COMMENTS**
Babbled	NEVER	PAST	PRESENT	

Pulled others to communicate wants/needs	NEVER	PAST	PRESENT	
Looked at others to communicate wants/needs	NEVER	PAST	PRESENT	
Pointed to communicate wants/needs	NEVER	PAST	PRESENT	
Used sign language	NEVER	PAST	PRESENT	
Used an augmentative communication device	NEVER	PAST	PRESENT	
Made 1-word requests	NEVER	PAST	PRESENT	
Made 2-3-word requests	NEVER	PAST	PRESENT	
Made full sentence requests	NEVER	PAST	PRESENT	
Asked questions (e.g. where, who, etc.)	NEVER	PAST	PRESENT	
Answered questions	NEVER	PAST	PRESENT	
Conversational with adults	NEVER	PAST	PRESENT	
Conversational with peers	NEVER	PAST	PRESENT	
Repeated words over and over	NEVER	PAST	PRESENT	
Spoke well but slow to develop language	NEVER	PAST	PRESENT	
Speech difficulties (i.e. difficult to understand)	NEVER	PAST	PRESENT	
Talked, but does not anymore	NEVER	PAST	PRESENT	
Followed simple instructions (e.g. come here, etc.)	NEVER	PAST	PRESENT	
Followed complex instructions (e.g. get dressed, etc.)	NEVER	PAST	PRESENT	
Play/Social				**COMMENTS**
Interacted with toys in a repetitive or unusual manner	NEVER	PAST	PRESENT	
Played with electronic toys as designed	NEVER	PAST	PRESENT	
Played with non-electronic cause/effect toys (e.g. pound-a-ball, etc.) as designed	NEVER	PAST	PRESENT	
Played with manipulative toys (e.g. puzzles, blocks, etc.) as designed	NEVER	PAST	PRESENT	
Engaged in simple pretend play (e.g. feeds baby, etc.)	NEVER	PAST	PRESENT	
Engaged in elaborate pretend play (e.g. dollhouse scenarios, etc.)	NEVER	PAST	PRESENT	
Played with board/box games (e.g. Mousetrap, etc.) as designed	NEVER	PAST	PRESENT	
Played computer games as designed	NEVER	PAST	PRESENT	
Independently entertained self in play for up to 5 minutes	NEVER	PAST	PRESENT	
Readily explored new toys and activities	NEVER	PAST	PRESENT	
Usually played alone	NEVER	PAST	PRESENT	
Joined others in play	NEVER	PAST	PRESENT	
Appropriately interacted with parent(s)/guardian(s)	NEVER	PAST	PRESENT	

Appropriately interacted with sibling(s)	NEVER	PAST	PRESENT	
Appropriately interacted with peers	NEVER	PAST	PRESENT	
Difficulty sharing toys/waiting for a turn	NEVER	PAST	PRESENT	
Appropriately interacted with teachers	NEVER	PAST	PRESENT	
Appropriately interacted with other adults	NEVER	PAST	PRESENT	
Avoided eye contact	NEVER	PAST	PRESENT	
Avoided social interaction (e.g. turns away from others, etc.)	NEVER	PAST	PRESENT	
Encountered peer rejection	NEVER	PAST	PRESENT	
Made negative comments to others	NEVER	PAST	PRESENT	
Teased others	NEVER	PAST	PRESENT	
In competitive situations, overreacted when losing	NEVER	PAST	PRESENT	
Physical/Adaptive				**COMMENTS**
Displayed stereotypic behavior(s) (e.g. hand flapping, body tensing, etc.)	NEVER	PAST	PRESENT	
Poor motor coordination	NEVER	PAST	PRESENT	
Lethargic/low energy	NEVER	PAST	PRESENT	
Hyper/overly energetic	NEVER	PAST	PRESENT	
Excessively noisy (e.g. yells, etc.)	NEVER	PAST	PRESENT	
Fleeting attention span	NEVER	PAST	PRESENT	
Required constant attention	NEVER	PAST	PRESENT	
Often had physical complaints (e.g. headaches, stomachaches)	NEVER	PAST	PRESENT	
Had difficulty staying awake	NEVER	PAST	PRESENT	
Had difficulty falling asleep	NEVER	PAST	PRESENT	
Had difficulty staying asleep	NEVER	PAST	PRESENT	
Took naps regularly	NEVER	PAST	PRESENT	
Had frequent nightmares	NEVER	PAST	PRESENT	
Had a self-limited diet (due to food refusal)	NEVER	PAST	PRESENT	
Fed self finger foods	NEVER	PAST	PRESENT	
Fed self with utensils	NEVER	PAST	PRESENT	
Disruptive at meal times	NEVER	PAST	PRESENT	
Toilet trained on a schedule	NEVER	PAST	PRESENT	
Initiated toileting	NEVER	PAST	PRESENT	
Cried, whined, or pouted frequently	NEVER	PAST	PRESENT	
Irritable	NEVER	PAST	PRESENT	
Tantrumed frequently	NEVER	PAST	PRESENT	
Engaged in self-injurious behavior (e.g. head banging, hand biting, etc.)	NEVER	PAST	PRESENT	
Engaged in aggressive behavior (e.g. hits, pinches, bites others, etc.)	NEVER	PAST	PRESENT	

Engaged in destructive behavior (e.g hits/throws objects, tips furniture, etc.)	NEVER	PAST	PRESENT	
Difficulty responding to change in routine	NEVER	PAST	PRESENT	
Difficulty separating from parents/caregivers	NEVER	PAST	PRESENT	
Excessive fears	NEVER	PAST	PRESENT	
Recognized dangerous situations	NEVER	PAST	PRESENT	
Ran away/dashed from caregivers in the community	NEVER	PAST	PRESENT	
Ran away from home	NEVER	PAST	PRESENT	
Wandered off	NEVER	PAST	PRESENT	
Difficulty with disciplinary control (e.g. reprimands are ineffective, etc.)	NEVER	PAST	PRESENT	
Talked back to parent(s), guardian(s), or/other authority figures	NEVER	PAST	PRESENT	
Academic				**COMMENTS**
Academically performed at grade level in math	NEVER	PAST	PRESENT	
Academically performed at grade level in reading	NEVER	PAST	PRESENT	
Academically performed at grade level in writing	NEVER	PAST	PRESENT	

Additional Pertinent Information

List your child's favorite(s)- toys, activities, foods, characters, etc.

List your child's dislikes

Item/Activity/Other	His/Her Reaction(s)

What are the client's strengths?
What behavior(s) and skill deficit(s) concern you most?
What do you want for the child's future?
Is there any other information you could provide that would help ABC of NC staff prepare for serving the client/family?

Parent/Guardian Signature Date

ABC of NC

Transportation Policy for Third-Party Providers

Purpose
This policy outlines expectations and safety procedures for third party transportation to ensure client safety, clinical consistency, and compliance with North Carolina Medicaid Non-Emergency Medical Transportation (NEMT) rules. It applies to all contracted transportation providers serving ABC of NC clients.

Appointment Timing

- Services begin and end strictly at the scheduled appointment time unless otherwise authorized by the clinical team or parent/guardian.
- ABC of NC staff are not responsible for supervising clients outside of scheduled service times.
- Services may be denied or rescheduled if transportation timing creates a safety or supervision concern.

Early Drop-Offs
Per NC Medicaid policy, unless otherwise requested by the recipient or guardian, providers may deliver clients:

- Up to **1 hour early** for single-loaded trips
- Up to **2 hours early** for multi-loaded trips

Provider Responsibilities:

- ABC of NC does not provide supervision before the scheduled session start time.
- If a client cannot wait safely and independently, a parent/guardian or caregiver must remain on-site with the client until the session begins.
- Written permission from the parent/guardian is required for unattended waiting. Without this documentation, a caregiver must remain on-site with the client until staff are available.

Waiting Requirements
Clients must remain in the designated waiting area before and after sessions while awaiting transportation. Providers must ensure timely pick-up to minimize unsupervised wait times.

Early Pick-Ups
Providers should arrive **no earlier than the scheduled end of the session**, unless:

- Prior approval has been given by the parent/guardian; or
- ABC of NC initiates an early release due to sickness, emergency closure, inclement weather, or other operational needs.

If transportation arrives early without approval:

- ABC of NC's Client Relations Coordinator will obtain real-time verbal consent from the parent/guardian before releasing the client.
- The incident will be documented in the client's electronic medical record.
- The event will be reported to the provider, parent/guardian, and the client's care coordinator or Managed Care Plan representative.

Provider Accountability:

- All late arrivals and early pick-ups will be documented in the client's electronic medical record.
- Repeated incidents will trigger notification to the provider, parent/guardian, and Managed Care Plan representative.
- Clients with chronic lateness or early departure patterns may face route reassignment, compliance review, schedule adjustments, or suspension of transportation services until reliability is restored.

Medicaid Transportation Restrictions

- Medicaid transportation cannot be used for school-related travel, including trips to and from schools, classrooms, or educational programs.
- Medicaid NEMT is limited to medically necessary appointments such as therapy sessions, medical visits, or pharmacy trips.
- Families must arrange separate transportation for all school-related services.

Repeated Transportation Issues or Safety Concerns

All early, late, or unsafe transportation incidents will be documented in the client's electronic medical record.

Repeated violations—including early arrivals, early pick-ups, chronic lateness, or unsafe wait times—will result in:

- Notification to the parent/guardian
- A request to contact the transportation provider, care coordinator, or Managed Care Plan representative to correct scheduling
- Possible reassignment of the transportation provider or temporary suspension of services until safety and schedule reliability are restored

Denial or Rescheduling of Services

- ABC of NC reserves the right to deny or reschedule sessions when client drop-off or pick-up occurs outside of safe and authorized timeframes.
- These incidents will be recorded as **transportation-related**, not as client no-shows.

Communication with Transportation Providers

This policy will be shared with all transportation providers, Managed Care Plan representatives, parents/guardians, and caregivers.

ABC of NC will request scheduling modifications as needed to maintain client safety and compliance with Medicaid transportation requirements.

My signature below indicates that I understand and agree to adhere to this policy.

____

Client Name

____ ____________________

Parent/Guardian Signature Date

ABC of NC

Client Rights, Responsibilities, and Informed Consent

1. ABC of NC assures basic human rights to each of its clients, including the right to dignity, privacy, human care, and freedom from mental and physical abuse, neglect, and exploitation. We assure our clients' rights to live as normally as possible while receiving care and treatment in accordance with G.S. 122C-51.
2. Each client has the right to treatment, including access to medical care and habilitation, within the agency's scope of training. Each client has the right to an individualized written education or treatment plan setting forth a program to maximize the development or restoration of her/his capabilities.
3. It is the policy of ABC of NC to inform clients/legal guardians of their rights and responsibilities and to gain informed consent for treatment.
4. 4. Each new client is informed of client and family rights and responsibilities as well as informed consent for treatment through the new client intake packet and at the time, they sign the individualized education and/or treatment plan. Each client must sign acknowledging receipt and understanding of their rights, responsibilities, and consent for treatment prior to treatment delivery.
5. The client/guardian shall receive the following policies and notification as part of the intake process, and no later than 72 hours subsequent to onset of services at ABC of NC:
    a. A parent/caregiver handbook, including confidentiality policies, policies addressing the use of restrictive interventions, the procedure for obtaining a copy of the client's education or treatment plan
    b. After-hours resources and emergency care information
    c. Client payment, attendance, discharge, and referral policies, which include fee assessment and collection practices.
    d. Confidentiality, privacy, and HIPAA practices
    e. Client rights, responsibilities, and informed consent policies
    f. Electronic communication policy
    g. Grievance policy
6. The following education/treatment documents must be signed by the parent/guardian prior to implementation and is considered informed consent:
    a. Individualized Education Programs (IEPs)
    b. Individualized Treatment Plan
    c. Behavior Intervention Plans (BIPs)
7. Each IEP, treatment plan, or behavior intervention plan must indicate the length of time the consent is valid; the alleged benefits, potential risks, and alternative methods of treatment/habilitation; and the procedures that are to be followed if the parent/guardian chooses to withdraw consent.
8. Each voluntary client or legally responsible person has the right to consent or refuse treatment in accordance with G.S. 122C-57(d). A voluntary client's refusal of consent shall not be used as the sole grounds for discharge or threat of discharge unless the procedure is the only viable treatment/educational option available at the center.
9. All ABC of NC staff will receive training and be fully informed of the rights of the clients and families they serve, and all staff will be expected to respect these rights.
10. Each staff person will be required to sign the Employee Acknowledgement and Receipt of Policies and Procedures Manual form indicating that they have been informed of client rights and those policies related to client rights. Ongoing

discussion and training will occur as deemed necessary by the executive director, psychologist, and/or employee's supervisor. Employees will also be notified of any changes to client rights policies.

11. Client rights, responsibilities, and consent for treatment are outlined in the policies and procedures manual and are as follows:
    a. **Clients have the right to:**
        i. Be treated with dignity and respect.
        ii. Fair treatment regardless of race, religion, national origin, gender, gender identity, ethnicity, culture, sexual orientation, age, disability, neurodiversity, socioeconomic status or source of payment.
        iii. Be free from mental, physical, sexual, and psychological abuse; neglect, financial or other exploitation; harassment and physical punishment, retaliation, and humiliation.
        iv. Have their treatment and other client information kept private. Only where permitted by law, records may be released with client permission.
        v. Easy access to timely care.
        vi. Freedom to participate, or to refuse participation in accessible community activities, and in social, political, medical, and religious resources.
        vii. Decisions about their care made without regard to financial incentive.
        viii. Be notified should program funding be discontinued
        ix. Know about their treatment choices and share in developing their treatment options, and be given information about clinical guidelines used in providing and managing their care.
        x. A clear explanation of their condition and treatment.
        xi. Information about their health care insurance coverage and, if applicable, its role in the treatment process.
        xii. Ask their provider about their work history, training, and licensure.
        xiii. Be encouraged to exercise their rights as a citizen and a client, and be permitted to make complaints, suggestions, or appeals without fear of coercion or retaliation.
        xiv. Dignity, privacy and humane care in the provision of personal health care. xv. If a minor, seek and receive periodic services from a physician without parental consent in accordance with G.S. 90-21
        xv. Contact and consult with a consumer advocate. Contact Disability Rights NC, which is the North Carolina State agency responsible to protect and advocate the rights of persons with disabilities.
        xvi. Keep and use personal property and clothing under appropriate supervision, unless specifically prohibited by law.
        xvii. Know the rules that the client is expected to follow and possible penalties for violations. xx. In the event that restrictive intervention is needed, per 27D .0303 (b), there must be informed written consent for planned use of a restrictive intervention. This would be included in the treatment and/or behavior intervention plan.
        xviii. Be free from chemical and physical restraint.
        xix. Be free from unnecessary/excessive medication and for medication not to be used for punishment, discipline, or staff convenience.

xx. To request a copy of their treatment plan in writing allowing ABC of NC 7-10 business days to provide the information.
xxi. Consent to treatment or refuse treatment.

b. **Clients have the responsibility to:**
   i. Treat those giving them care with dignity and respect.
   ii. Give provider information needed to deliver the best possible care.
   iii. Ask questions about their care to help them understand the care being provided.
   iv. Follow the treatment and/or education plan. The treatment and/or education plan is jointly created by client and provider.
   v. Tell their provider and primary care physician about medication changes, including medications given to them by others.
   vi. Keep their appointments:
      1. Please see Client Payment and Attendance Policies for details on charges for missed appointments.
   vii. Let the provider know when the treatment and/or education plan is no longer working for them.
   viii. Openly report concerns about the quality of care they receive.
   ix. Report abuse and fraud.

Informed Consent for Treatment:
By signing below, I consent to participate in behavioral health and educational assessments, services, and treatment provided by ABC of NC Child Development Center, including school-based, related, and outpatient mental health services.

Risk/Benefits:
Benefits may include improvements in communication, social relationships, play, self-care, school readiness, and employment.

Risks may include changes in daily routines, variable progress rates, temporary increases in problem behaviors, and feelings of frustration during intervention.

I consent only to services that ABC of NC staff are qualified to provide within the scope of their education, training, and licensure/certification. If the client is under 18 or unable to consent, I attest that I have the legal authority to do so on their behalf. I have reviewed the emergency care information and client rights and responsibilities. A copy of this form will be provided upon request.

> *ABA Services* includes activities, goals, desired outcomes, one-on-one therapy, training, parent and family trainings, community outings/field trips, etc. *Risks* may include changes in everyday life to adapt to therapy, some individuals progress quickly while others take longer to acquire skills, feelings of upset and frustration due to tolerating behavioral intervention reaction, initial increases in the duration, frequency, and/or intensity of problem behaviors.
>
> *Psychological Services* includes evidence-based counseling and psychotherapy and can have numerous benefits, which involves behavioral health assessments and evaluations, cognitive behavioral therapy, behavioral modification, collaborative problem-solving, applied behavior analysis, parent education and support, and more.

Benefits may include a significant reduction in feelings of distress, increased skills for managing stress and resolutions to specific problems. There are no guarantees about what will happen but it requires an active effort and working on things discussed in session outside out of sessions. Assessments and evaluations can assist your doctors, therapists, and other health professionals *Risks* may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness because the process requires addressing and discussing the unpleasant aspects.

Educational services includes educational assessments and evaluations designed to target individual's needs through small group instruction. *Benefits* may be individualized to include both group instruction and one-on-one intensive services. The classes include target skills such as communication, play/social skills, adaptive living skills, and small group instruction/classroom routines. I understand that there may be both risks and benefits associated with participation in the learning environment.

Telehealth services is an option when client do not attend in-person sessions. *Risks* includes other people overhearing sessions if the client is not in a private place during sessions, we may not be able to provide services necessary in an urgent or emergency situation, there are concerns about a clinician's ability to fully understand non-verbal information when working remotely and increased opportunities for miscommunication. Clients will be required to sign a separate Telehealth Consent Form with further details of benefits and risk.

Artificial Intelligence (AI) Use and Data Transparency:
ABC of NC may use artificial intelligence (AI)–supported tools to assist with administrative or clinical tasks such as documentation, data organization, scheduling, or treatment plan review.

AI tools do not make independent clinical decisions and do not replace the professional judgment of licensed or credentialed providers. All treatment decisions and documentation are reviewed and approved by licensed clinical staff or other qualified staff before being finalized or shared.

Client information used in any AI-assisted system is handled in compliance with the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and other applicable privacy laws.

When AI tools are used, data are either de-identified or processed securely within controlled systems.

Clients and caregivers have the right to:
- Request information about how AI tools are used in their care.
- Ask questions about data handling, privacy, and security.
- Decline the use of AI-assisted tools in their treatment, understanding that traditional methods will then be used.

By signing below, I acknowledge that I have been informed of the potential use of AI-assisted technologies at ABC of NC. I understand these tools are used to support, not replace, professional services, and that qualified providers remain fully responsible for all aspects of assessment, treatment, documentation, and decision making. I understand that I am consenting and agreeing only to those services that ABC of NC staff is qualified to provide within the scope of their education, training, and licensure/certification.

If the client is under the age of 18 or unable to consent to treatment, I attest that, I have the legal authorization to initiate and consent for treatment on behalf of this individual. I have reviewed the emergency care information and client rights and responsibilities. Treatment and/or education plans will include individualized informed consent consistent with the type of service(s) rendered. A copy of this form will be provided to me upon request.

Name of Client	Date of Birth
Signature of Legally Responsible Person	Date
Signature of ABC of NC Staff Witness	Date

ABC of NC

Client Payment, Attendance, Discharge, and Referral Policies

1. **Payment policies for diagnostic, therapeutic, and ABA therapy services (Clinic Services)**

   Payments are due in accordance with insurance policies and are billed on a fee-for-service basis.

   a. Clients receiving testing, counseling, and other diagnostic or psychotherapy services must pay assigned copay at time of services.
   b. ABA clients with a copay must pay their assigned copays bi-weekly. Copays are due by 5:00 PM for all services provided during that two-week period.
   c. All clients with co-insurance will be invoiced monthly. Invoices must be paid in full by the date listed on the invoice.
   d. Copays and coinsurance may be paid at the clinic reception desk Monday-Friday between 8:00 AM- 5:00 PM by credit or debit card. Additionally, those paying by check may place a check in the clinic payment box located in the clinic front lobby. Credit card payments are also accepted on our website: www.abcofnc.org.
   e. Payments are considered late if not received within 30 days from the date of the invoice.
   f. Insurance Payments
      i. It is important for clients to be informed consumers, who understand the specifications of their insurance policies (e.g. coverage, referral/authorization requirements, etc.). The client's health insurance policy is a contract between the client and her/his health insurance company or employer. It is the client's responsibility to know if their insurance policy has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, and limits on outpatient charges regardless of whether or not our providers participate.
      ii. Clients must present a current insurance card if a new card has been issued and/or if there are any changes to their coverage. As a courtesy to our clients, ABC of NC will bill your insurance company directly for behavioral health services rendered, provided we are credentialed with your insurance company for the specific service. If problems arise regarding coverage issues, we will attempt to work with the client's insurance company to help resolve them prior to making it the client's responsibility. However, clients are ultimately financially responsible for payment of behavioral health services rendered.
      iii. If you do not present a current insurance card, you will be responsible for payment at the time of your visit. You will receive reimbursement from ABC of NC if your insurance pays the claim at a later date. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicaid

consider some services to be “non-covered,” in which case you are responsible for payment in full.

iv. If your insurance changes, please notify us before your next visit so we can ensure we have the most up to date and accurate information on file.

v. According to NC Statute 58-3-225(b), insurers are required to pay a properly submitted claim within 30 days. You have a responsibility to provide copies of insurance cards to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days, the balance will be transferred to your account and you will be responsible for payment. If we receive payment from your insurance provider at a later date, you will be reimbursed. If you are uncertain about your current health insurance policy benefits, you should contact your provider to learn the details about your benefits, out-of-pocket fees, and coverage limits.

vi. ABC of NC contracts with many insurance plans. Before your appointment, please confirm that we are considered in-network and the services are covered under your plan. If we are considered out-of-network, you will be billed for the cost of care.

vii. If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

viii. Clients who receive ABA therapy services will be responsible for signing an ABA Estimated Benefits and Coverage form; this form must be signed before services begin in order to confirm you have an understanding of your coverage and potential out-of-pocket costs. This form must be updated annually and any time your insurance coverage changes.

2. **School/Tuition-Based Services Payment Policies (ABC of NC School)**

Clients enrolled in tuition-based services receive parent/caregiver classes, team meetings, and quarterly home visits at no additional cost.

a. A deposit in the amount of one-month’s tuition is required in order to hold a client’s slot (current fees are available on the ABC of NC website). This deposit will be kept on hand throughout the duration of service delivery to ensure that ABC of NC receives a 30-day notice of intent to discontinue services. The deposit, minus any outstanding balance for late-charges or other charges, will be returned to clients upon termination of services, provided that ABC of NC receives a 30-day written notice of intent to discontinue services. The deposit is forfeited if services are cancelled without a written 30-day notice.

b. Tuition will be billed the first of the month and payment is due within 20 days of invoice.

c. Tuition is non-refundable. No refunds will be issued for client absences, inclement weather days, or other occasions, nor can these days be made-up (with the exception of scheduled inclement weather make-up days).
d. When a client's medically necessary, authorized clinical treatment plan includes 1:1 ABA therapy delivered in a school setting:
    a. Group instruction tuition will be billed to the family or contracting school district (for students with out-of-district placements), and
    b. 1:1 ABA therapy will be billed to the client's private health insurance and/or Medicaid, and the family or contracting school district (for students with out-of-district placements) will be responsible for any co-pays, co-insurance, or fees not covered by the insurance plan/Medicaid.
e. Supplemental services, such as speech, occupational, and physical therapies and mental health counseling may be delivered during the student's school day in either the therapist's office or in the student's classroom. School tuition is not prorated for supplemental services that occur within the student's school day.
f. Late Pick-Up Charges: Clients will be assessed a fee if the client is picked up late from school. During final dismissal (i.e. 2:30 pm), due to heavy traffic in the carpool line, late pick-up charges begin incurring at 2:40 pm and are charged at the following rates:
    a. $10.00 (5-14) minutes late
    b. $50.00 (15-30) minutes late
    c. $100.00 (31 or more) minutes late
g. Services, such as additional consultation, that are not covered by the tuition fees are charged in addition to the monthly tuition. These charges are billed in quarter-hour increments following the provision of services. Hourly service rates apply.

3. Returned Checks/Electronic Payments

Clients who have one check returned to ABC of NC will be requested to replace the returned check with cash, money order, or a cashier's check.

a. A returned item service fee as allowed by North Carolina State Law ($25) will be assessed on all funds returned.
b. ABC of NC will maintain a list of clients who have returned checks/insufficient funds, which will include those who have had two or more returned items within a 12-month period.
c. Clients who have two or more returned items within a 12-month period are required to submit only cash or certified payments for a minimum of 12 months after receiving the second returned items

4. Accounts Receivable Collections

When necessary, ABC of NC may utilize collections agencies, small claims courts, or litigation to attempt to collect a debt.

a. Account balances must have a minimum debt of $250.00 in order to be sent to a collections agency.

5. Attendance Policies

Regular attendance is an essential part of successful and effective therapy. Regular attendance can assist clients in reaching goals and maintaining gains in treatment.

a. Late cancellation fees are established based on the amount of effort and time it takes for Scheduling to coordinate changes to clients' and employees' schedules. This is directly related to how timely a client is in providing advanced notice by calling the Scheduling team to make these changes, so that the client's education and care, along with the impacted employees' schedules, have as little disruption as possible.

b. Clinic Attendance for ABA Therapy, Counseling, and Diagnostic Services
    a. Absences will be coded and late cancellation/no show fees charged (when payer allows) as follows:
        1. Planned absence, including tardies/early departures (including scheduled parent/caregiver meetings):
            a) Client provides a 15-business day written notice to scheduling@abcofnc.org – no charge
            b) Client provides less than 15-business day notice - $25 late cancellation fee
        2. Unplanned absence (including scheduled parent/caregiver meetings):
            a) Full Day
                - Client calls ABC of NC's scheduling department (ext. 120) prior to 7:00 am on the day of the absence- $75 late cancellation fee
                - Client calls ABC of NC's scheduling department (ext. 120) after 7:00 am on the day of the absence- $150 late cancellation fee
            b) Partial Day (Tardy/early dismissal)
                - Usual and customary rates will be billed to client family for time missed
        3. No show – Client does not arrive for services (including scheduled parent/caregiver meetings) and doesn't notify the scheduling department - $189 no show fee
    b. Any late cancellation or no show fees are the responsibility of the client and will not be billed to any other payer. Payment of late cancellation/ no show fees must be paid by the date listed on the invoice where these charges are applied.
    c. Please note that clients who are dually enrolled in ABC of NC's school and ABA therapy services are still expected to be in attendance for ABA therapy sessions even when the school is closed for breaks or staff workdays.

c. Additional Guidance for Counseling and Diagnostic Services
    a. Clients and families are expected to arrive 5-10 minutes before their scheduled appointment. A parent/guardian must remain with the client until the client is in the clinician's care.
    b. Clients receiving testing, counseling, and other diagnostic or psychotherapy services must have a parent/guardian remain in the clinic lobby throughout the duration of the service.
    c. Clients who are more than **15** minutes late for an appointment may not be seen for session and/or may need to be rescheduled. Sessions that start late may not be billable to insurance.

d. School Attendance
   a. If a client will be absent for all or part of a day, the parent/guardian should notify the receptionist by phone as soon as possible to ensure that the scheduling coordinator can adjust the daily schedule. Parents/ guardians should also notify the front office by phone if a client will be arriving late so that staff can remain productive throughout the day.
   b. As a courtesy, if a planned absence is changed, please provide at least 24 hours' notice to the front office so that the schedule can be readjusted to accommodate the client's attendance.
   c. After 8 absences, the client's parent/guardian and program supervisor and will meet to address concerns about excessive absenteeism. After 12 absences, the client will receive a letter addressing concerns about excessive absenteeism. After 16 absences, the client will receive a second letter and meeting to address concerns about excessive absenteeism. Any absence beyond the 16th absence will require official documentation (e.g. doctor's note, etc.).
   d. The accumulation of five (5) tardies or early dismissals will equate to one (1) absence.
   e. ABC of NC reserves the right to refer families to another provider when there is chronic absenteeism.

6. Discharge and Referral Policies

Discharge

a. Active discharge planning is a component of each individual's treatment/education from the time of admission to discharge from outpatient therapy, ABA therapy, or educational services.
b. In the event the client, a family member, or a third-party caregiver is rude, uses disparaging or demeaning language, or sexually harasses office personnel or other patients, visitors, or vendors; exhibits violent or irrational behavior; makes threats of physical harm; or uses anger to jeopardize the safety and well-being of anyone present in the office, ABC of NC reserves the right to discharge the client immediately from all services.
c. In the event the client, a family member, or a third-party caregiver wields a firearm or weapon on the premises, ABC of NC reserves the right to discharge the client immediately from all services.
d. For outpatient counseling services, when at least one of the following criteria is met:
   1. The client's level of functioning has improved with respect to the goals outlined in the treatment plan; or
   2. The client or legally responsible person no longer wishes to receive these services; or
   3. The client, based on presentation and failure to show improvement, despite modifications in the treatment plan, requires a more appropriate best practice or evidenced based treatment modality.
   4. The family and provider are not able to reconcile important issues in treatment planning and delivery, including lack of participation or significant time gaps between appointments (e.g. client should attend at least 85% of scheduled sessions; client should have no more

than 3 no shows).

e. For ABA therapy and educational services, when at least one of the following criteria is met:
    1. The client has achieved all of the treatment goals set our at the initiation of the service or the majority of them; or
    2. The client has mastered the skills on relevant assessments consistent with community standards of care; or
    3. The client no longer meets diagnostic criteria for Autism Spectrum Disorder (as measured by appropriate standardized protocols) or no longer is appropriate for the particular service type; or
    4. The client is in need of other services to address co-morbid diagnoses that may limit the efficacy of ABA service; or
    5. The client's clinical condition has become such that he or she requires a higher level or intensity of care; or
    6. The client does not demonstrate progress toward goals for two successive authorization periods; or
    7. The family/caregiver is interested in discontinuing services; or
    8. There is failure to provide payment for services; or
    9. The family and provider are not able to reconcile important issues in treatment planning and delivery, including lack of participation (client should attend at least 85% of scheduled sessions; client should have no more than 3 no shows).

f. Upon discharge
    1. Caregivers meet with appropriate ABC of NC staff for review of treatment/educational recommendations, update discharge planning paperwork, and complete a discharge summary.
    2. A discharge summary must be placed in the client's file.

Referrals

a. When situations arise in which a client may require referrals to other service providers and/or for other ABC of NC services, the appropriate ABC of NC staff member will make a written referral.
b. Client specific information will be shared with referral sources only with signed disclosure forms.
c. In the event a client is discharged or referred to other services, this does not exclude them from the ability to participate in services with ABC of NC in the future. However, returning to services at ABC of NC is contingent upon meeting admission criteria and pending program capacity.

I have read and understand the ABC of NC Payment, Attendance, Discharge, and Referral Policies and agree to abide by these policies.

____ _______________________

Signature of client/responsible party Date

____ _______________________

Signature of ABC of NC witness Date

ABC of NC

Authorization of Medication Administration or Discontinuation

Select one:

- ❑ Medication Authorization
- ❑ Medication Adjustment
- ❑ Medication Discontinuation

Name of Client:____Date of Birth:__________

TO BE COMPLETED BY PHYSICIAN/ MEDICAL PROVIDER FOR AUTHORIZATION OR ADJUSTMENT

Prescribing Health Care Clinician:______________________________Phone Number: _____________

Name of Medication: _____________________________
Type of medication: ⎯ Prescription ⎯ Over-the-Counter ⎯ Dietary Supplement
Circumstance(s) of administration: ⎯ Routine Medication Administration ⎕ As needed
***Is this a psychotropic medication?** ⎯ **Yes** ⎯ **No**
*Psychotropic medications must get approval every 6 months from the prescribing physician/medical provider
Dosage:_______________________________________
Administration Method: ⎯ Client will self-administer† ⎯ Staff will administer
†This includes medications and/or dietary supplements that are added into a child's food or drink for self-consumption.
Can this medication be stored centrally, or must it be carried with the client? _______________
Is this medication administered on an 'as needed' basis for emergencies? _________________
Please list Urgency and Timeframe in which medication must be given below.

Time(s)/ Circumstance medication is to be given	Special Instructions	Potential Side effects

NOTE: "Lunch Time" may vary between 11:30 am- 1:00 pm

Signature of Physician/ Medical Provider:________________________________Date: _______________

TO BE COMPLETED BY PHYSICIAN/ MEDICAL PROVIDER FOR DISCONTINUATION

Prescribing Health Care Clinician:______________________________Phone Number: _____________
Name of Medication: _____________________________
Signature of Physician/ Medical Provider:________________________________Date: _______________

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby authorize my child,________________________________, to receive or discontinue the above medication or dietary supplement in accordance with the physician's orders. I agree to send the medication or dietary supplement in the original container labeled with: my child's name, the name of the medication/supplement, the dosage(s) to be given, and the method of administration. I agree to maintain communication with the staff regarding any changes in my child's condition, medication, and other health needs at ABC of NC. I hereby release ABC of NC, and their employees and agent from any and all liability that may result from my child taking or discontinuing the above medication or dietary supplement.

Signature of Parent/ Guardian:_______________________________________Date:________________
Phone Number of Parent/ Guardian:____

ABC of NC Safety Officer or Designee must complete page 2

TO BE COMPLETED BY ABC OF NC SAFETY OFFICER OR DESIGNEE

- ❑ Medication Authorization
  Placed updated Medication and form in: School Health Room__________Clinic Health Room __________
  Staff Signature____ Date: _______________________________

- ❑ Medication Adjustment
  Date Received Updated form and Adjusted Medication: ____
  Placed updated Medication and form in: School Health Room__________Clinic Health Room __________
  Date Original Medication Returned to Parent/Guardian: ____
  Staff Signature ____

- ❑ Medication Discontinuation
  Date Medication Returned to parent/guardian: ____
  Quantity Returned:_____________________Reason for Return (expired/discontinued): _________________
  Staff Signature: ____

ABC of NC

After-Hours Resources/ Emergency Care Information

Your wellness is our priority. If it is after business hours and you are experiencing a crisis and cannot wait until your next scheduled appointment, please contact one of the emergency numbers below, you are welcome to leave a message on our confidential voicemail. We aim to respond to your phone calls within 15 minutes. **If your needs require immediate attention or are life threatening, please call 911 or go directly to the closest Emergency Department.**

- Clinic clients (outpatient therapy) who experience an after-hours emergency may call 336-971-7788.
- Applied Behavior Analysis (ABA) therapy clients who experience an after-hours emergency may call 336-276-3754.

Mental health emergencies may also be directed to Mobile Crisis during business hours and after hours. Various counties in NC offer 24/7 crisis response or assessment services and are listed below by county served:

Guilford and Randolph County: Therapeutic Alternatives 877-626-1772; Monarch/Sandhills Mental Health Center Helpline 800-256-2452

Davidson, Davie, Forsyth, Stokes, Rockingham, Rowan Counties: Forsyth Medical Center 1-800-718-3550 or Cardinal Innovations Mobile Crisis at 800-939-5911

Surry, Yadkin, Iredell Counties: Partner's Behavioral Health Help Line 888-235-4673

24/7 Face-to-face Assessments available on site at the following hospitals:

Cone Behavioral Health Services (5 years old and up): 336-832-9700 or 1-800-711-2635; 700 Walter Reed Drive, Greensboro
Old Vineyard Behavioral Health Services (12 years old and up): 336-794-3550 or 1-855-234-5920; 3637 Old Vineyard Rd, Winston-Salem

Please initial below:

________ I request a copy of the after-hours resources and emergency care information.

________ I declined a copy of the after-hours resources and emergency care information.

I have read and understand the after-hours resources and emergency care information.

______________________________________ ________________
Signature of Parent/Guardian Date

______________________________________ ________________
Signature of ABC of NC Witness Date

speech★center, inc.

SPEECH-LANGUAGE REFERRAL

Date received: ______________

by Phone Fax E-mail **for** Evaluation (known concern/physician referral) Screening (undiagnosed/unsure) Transfer Services

Patient Name: ______________________ Patient D.O.B: ______________

Parent(s) Name: ______________________ Email: ______________

Address: ______________________ City/St/Zip: ______________

Phones: Home ______________ Work ______________ Cell ______________

Best #/Time to Call

Physician Information	**Referred from ABC of NC CDC**
Dr. Name: ______________ Practice: ______________ Address: ______________ City/St/Zip: ______________ Phone #: ______________ Fax #: ______________ Orders Sent: ________ Orders Rec: ________	☐ **Current Center-Based Services** ☐ **Current Non-Center Based Services** ☐ **New** ☐ **Clinic Only** **ABC Contact: Leigh Ellen Spencer** **Phone# 336-251-1180 x120** **LeighEllen.Spencer@abcofnc.org**
Primary Insurance Information	Secondary Medicaid/HealthChoice Information
Carrier: ______________ Insured's Name: ______________ Insured's D.O.B.: ______________ Policy #: ______________ Group #: ______________ Phone #: ______________	Medicaid ID#: ______________ HealthChoice #: ______________ Copay amount: ______________
Reason for referral/primary concern: Medical History: Best Days/Times for Parent/School: Comments:	**FOR SPEECHCENTER USE ONLY** *Funding Source:* ______________ *Contacted Parents:* ______________ *Sent Permission Forms:* ______________ *Rec'd Permission Forms:* ______________ *Contract for Services:* *Sent* ________ *Rec'd* ________ *Sent to Clinician:* ________ *Date:* ________ *Place of Service:* ______________ *POS Contact:* ________ *Phone#:* ________

ABC of NC CDC Use:

FAX COMPLETE REFERRAL FORM TO: *336-542-2054*

Any questions, please call 1-800-323-3123

rev 10/5/16 MLR

Phone: (816) 863-0799
Fax: (336) 313-0989
www.circletherapypeds.com

Referral for OT Services

Date of referral:________________ Location desired:____________________________

Primary physician name:________________________
Name of practice:_____________________________

Child's First Name:____________________Middle:_____________Last:__________________
DOB:____________________ Diagnosis (if applicable)______________________________
Parent / Guardian name:____
Address:____
Phone:_______________________ Email:____

Primary Insurance:______________________ Primary Insurance ID number_______________
Secondary Insurance:__________________ Secondary Insurance ID number_______________

Area of concern:

___ fine motor ___ gross motor ___sensory processing
___ feeding / oral motor ___ swallowing ___ visual motor / perceptual
___ social- emotional ___ safety ___ ADLs / self-care

Please add any additional information about areas to be evaluated: _______________________
____
____
____
____

Please send this referral sheet along with the checklist "What is OT?" to office@circletherapypeds.com

The HIPAA privacy rule requires covered entities to safeguard certain Protected Health Information (PHI) related to a person's healthcare. Information being sent to you may include PHI, after appropriate consent, acknowledgement, or authorization. You, the recipient, are obligated to maintain PHI in a safe and secure manner. You may not re-disclose this patient information without additional patient consent. Unauthorized re-disclosure or failure to safeguard PHI could subject us, or you, to penalties described in federal (HIPAA) and state law. If you, the reader of this message, is not the intended recipient, please notify me immediately and destroy the related message.

ABC of NC

Telebehavioral Health and Educational Services Informed Consent

Telebehavioral health is an electronic software platform which allows clients and clinicians to communicate when they are not in the same physical location. The platform transmits audio and visual information in real time via internet. In order to comply with state laws, ABC of NC only provides telebehavioral health services by a clinician located in the State of NC and to clients located in the State of NC.

There are potential benefits and limitations/risks associated with the use of the telebehavioral health services:

Potential Benefits: Telebehavioral health may be an option for clients to receive services from their clinicians when a client is unable to attend in-person sessions at ABC of NC. This platform can be helpful to ensure continuity of care in situations such as, but not limited to: client takes an extended in-state vacation, client and/or clinician move to a different area in the state, or the client is unable to meet in person for various reasons. Telebehavioral health requires technical competency from both parties.

Potential Risks: ABC of NC will take reasonable steps to ensure client privacy through the use of telebehavioral health and educational services, however, there are risks involved.

- Risks to confidentiality: Clients receiving telebehavioral health or educational services have a potential for others to overhear sessions. To maintain privacy, clients are expected to participate in telebehavioral health services in locations that are free of interruptions, distractions (i.e. cell phones, iPads, or other devices), and other people, when possible.
- Crisis management and intervention: Individuals in crisis situations requiring high levels of support and intervention will not be able to access ABC of NC using telebehavioral health services. ABC of NC is not equipped to provide telebehavioral health services during urgent or emergency situations.
- Efficacy: Telebehavioral health can be effective for ABA therapy, counseling, and psychotherapy. These services can be most effective for parent/caregiver trainings, technician trainings, supervision, and overall client support. There are increased opportunities for miscommunication when working remotely.

Alternatives to Telebehavioral Platform: Clients who choose to not participate in telebehavioral or educational services may receive services in-person at ABC of NC and/or have services placed on hold until in-person services are available.

Appropriateness of Telebehavioral Health and Educational Services: If ABC of NC's provider determines telebehavioral health is no longer the most appropriate form of treatment for the client, the provider will inform the client. The provider will discuss alternative options for treatment, including in-person services; parent/caregiver training; parent/caregiver classes; and, when appropriate, referral to another professional.

Confidentiality: ABC of NC has legal and ethical responsibilities to make best efforts to protect all communication that is part of our telebehavioral health and educational services. Due to the nature of electronic communication technologies, ABC of NC cannot guarantee all communications will be kept confidential or that others may not gain access to our communications. ABC of NC uses updated encryption methods, firewalls, and back-up systems to ensure privacy for client information; however, there is a risk that electronic communication may be compromised; unsecured; or accessed by others, including by the client's infrastructure. Clients are expected to take reasonable steps to ensure the security of communications including but not limited to: using secure networks, avoiding public or free Wi-Fi, and using passwords to protect the electronic device.

The extent of confidentiality and exceptions to confidentiality outlined in ABC of NC's Client Rights, Responsibilities, and Informed Consent are applicable to all telebehavioral health and educational services.

Electronic Communication: To access telebehavioral health services, clients may need specific webcams, computers, tablets, or smartphone systems. The client is solely responsible for any cost associated with obtaining necessary equipment, accessories, or software required to access telebehavioral health services.

ABC of NC will communicate via phone, email, and text message with electronic communication permissions and only for administrative purposes unless prior agreement was made between ABC of NC and the client. Email and text message communication between ABC of NC and the client should be limited to administrative matters only. ABC of NC cannot guarantee confidentiality of any information communicated via text messages and therefore will not disclose any clinical information via text messages.

Emergency Response Plan: In the event services are interrupted due to an emergency situation with the client, the client should not call the provider back. The client should call 911 or go to the nearest emergency department. If the client is experiencing a behavioral crisis that should be addressed by a mobile crisis team, the provider will supply the client with contact information for the mobile crisis team in the client's area. Provider will follow up with the client by phone within 24 hours of an emergency or behavioral crisis.

Emergencies with Technology: When conducting telebehavioral health rather than in-person therapy, it can be more difficult to assess and evaluate threats and/or other emergencies. In an effort to address some of the difficulties, the provider will supply their phone number in the event of the session being disconnected and will document information prior to the start of session including but not limited to:

- The client's current location
- An emergency contact person in the event of a crisis or emergency to assist in addressing the situation
- Best contact information for the client

In the event of technical problems when the client is not in crisis or an emergency situation, the client should disconnect from the telebehavioral health session, wait approximately one minute, and then attempt to re-connect to the platform.

<u>Fees:</u> Fee rates for telebehavioral health services are the same rates as in-person services. Not all insurance and managed care providers cover therapy sessions conducted via electronic devices. If a client's insurance, HMO, third party payor, or other managed care provider does not cover telehealth services, the client will be financially responsible for services rendered under ABC of NC's usual and customary rates. Clients should contact their insurance provider(s) prior to service delivery to determine if there is telebehavioral health coverage. In the event of technological failure during a telebehavioral health session and connection is unable to resume, the client will be charged the prorated amount of the service received.

<u>Record Keeping:</u> ABC of NC's telebehavioral health services shall not be video and/or audio recorded in any manner unless agreed upon by both parties. ABC of NC will maintain documentation of all sessions in accordance with our policies, codes of ethics, and laws.

This consent is intended as a supplement to ABC of NC's Client Rights, Responsibilities, and Informed Consent and does not amend any terms of that agreement.

☐ Consent to telebehavioral health: I, ______________________, verify that I have been informed and understand the benefits and risks associated with the use of telebehavioral health services with ABC of NC. I understand the confidentiality of my child's private health information may be compromised when sent through electronic transmission. I agree to the terms listed above and consent to participate in ABC of NC's telebehavioral health platform, including school and related services and/or outpatient/in-home behavioral health services. I understand that I am agreeing and consenting to services that ABC of NC staff are qualified to provide within their scope of education, training, and licensure/certification.

☐ Do not consent to telebehavioral health: I ______________________, decline to participate in telebehavioral health and educational services. I understand that receiving no treatment may result in increased risk to my child and/or family. I understand that I may still contact my provider by phone or email for consultation.

If client is under the age of 18, or is unable to consent to treatment, a parent/legal guardian may attest legal authorization to initiate and consent on behalf of the individual.

_____________________________________ _________________________________

Client Name Date

____

Client Signature or Legal Parent/Guardian Signature

ABC of NC

Authorization for Release of Protected Health Information

I authorize **ABC of NC Child Development Center** to**:**

☐ Request ☐ Both request and release
☐ Release ☐ I do NOT give authorization to release information

The following information (please check all that apply):
☐ Behavioral/medical health records ☐ Educational records ☐ Other: ___________________________

For the purpose of (please check all that apply):
☐ Continued patient care ☐ Determination of eligibility of services
☐ Diagnostic clarification ☐ Other: ____

Communication Method (please check preferred method):
☐ Mail ☐ Verbal ☐ Fax ☐ Pick up in office ☐ Other: _____________________

Name: ____
(PCP, referring doctor, school agency, employer, etc.; list one per release form)
Address: ____
Phone: ____ Fax: ____

THESE RECORDS SHALL INCLUDE: psychological evaluation report(s) including mental health, developmental disability, and/or substance abuse diagnoses and any other information specified:

____

REVOCATION- *I understand that I have the right to revoke this authorization at any time by giving written notification to ABC of NC Child Development Center. However, the revocation will not be effective to the extent that action has been taken in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a right to contest a claim.*

I may refuse to sign this authorization. I understand that ABC of NC will not condition treatment, payment for services, enrollment, or eligibility for benefits on signing this authorization unless these services are provided to me for the purpose of creating health information for a third party (e.g., insurance company).

I understand that if my record contains information relating to HIV infection, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information.

I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule. However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not redisclose such information without my further written authorization unless otherwise provided for by state or federal law.

____ _____________________________________
Client Date of Birth

____ _____________________________________
Client Signature (if over age 18 and only legal guardian) or Legal Representative/ Guardian Signature Date

____ _____________________________________
Legal Representative/ Guardian if applicable Relationship to Client

This authorization shall remain in effect for one year unless otherwise specified.

Date of expiration: ___________________________________

Witness: ____ Date:________________________________

ABC of NC

Transportation & Outing Permission Form and Liability Release

☐ My/our child, ____, has permission to

(Client name)

participate in individualized treatment plan/education plan outings planned by staff of ABC of NC Child Development Center (ABC of NC). I/we understand that adequate adult supervision will be provided during these outings.

☐ My/our child, ____, has permission to

(Client name)

participate in ongoing transportation between the ABC of NC and the preschool or daycare center known as

__________________________________ and located at________________________________.

(Facility name) (Facility address)

I/we understand that ABC of NC staff auto insurance provides primary coverage with secondary insurance provided by ABC of NC liability coverage for any events and/or damages not covered by ABC of NC staff automobile insurance.

I/we understand that these activities are designed to provide environmental stimulation, recreation or enjoyment and/or to work on goals from the client's individualized treatment plan/ education plan, at such times as ABC of Child Development Center staff feel that such outings would be in the best interest of the clients and their peers.

Liability Release

In consideration for allowing my/our child, ____________________________________, to participate in walking outings and auto transportation provided by ABC of NC, I/we hereby release ABC of NC, all employees of ABC of NC, and all volunteers who participate in the activities of the trips (directly related, as well as ancillary thereto,) from liability on my/our behalf and on behalf of my/our minor child, based on a claim of negligence arising in any way from my/our child's participation in the outings and activities which take place during the outings (i.e. all activities of whatever nature from the time my child leaves my care, custody and control in anticipation of the departure of the trips until the time my child is returned to my care, custody and control after the termination of the outings) except to the extent the injury is covered by any insurance procured by individual staff or by ABC of NC, which insurance does not allow for subrogation of the claim as against ABC of NC employees or volunteers alleged to have been negligent or to the extent and amount he injury is specifically covered by insurance providing coverage for the person or persons alleged to have been negligent. This release relates solely to ordinary negligence and does not apply to willful or wanton negligence or intentional misconduct on behalf of any employee or volunteer.

Additionally, I/we will specifically agree to indemnify and hold harmless, ABC of NC and employee or volunteer who participates in any aspect of the trips from any loss, damage, or demand sustained in any way related to my/our child's participation in the above designated trips whether from their alleged negligence or otherwise, except with respect to the individual employee or volunteer where the loss relates to willful or wanton negligence or willful misconduct of that ABC of NC employee or volunteer.

This release and indemnity as to ABC of NC is absolute to the extent not covered by insurance.

Parent/Guardian Printed Name ____

Parent/Guardian Signature ____

Date __________________________

ABC of NC

Permission for Child Pick-Up

ABC of NC only allows parents, legal guardians, or people designated by the parent(s) or legal guardian(s) to pick the client up from the center. Indicate below if you wish to give permission for someone other than the parent/guardian to pick up the client from the center. The designated person may be asked to show picture identification when s/he arrives to pick up the child. Any permission granted for child pick-up will remain effective until ABC of NC is notified in writing that below-listed person(s) are no longer permitted to transport the child from the ABC of NC premises.

_______________________________ has my permission to pick up my child,

(Name of person transporting child)

_________________________________ from the ABC Child Development Center premises.

(Child's name)

_________________________________ ____________________

(Parent/guardian signature) (Date)

_______________________________ has my permission to pick up my child,

(Name of person transporting child)

_________________________________ from the ABC Child Development Center premises.

(Child's name)

_________________________________ ____________________

(Parent/guardian signature) (Date)

_______________________________ has my permission to pick up my child,

(Name of person transporting child)

_________________________________ from the ABC Child Development Center premises.

(Child's name)

_________________________________ ____________________

(Parent/guardian signature) (Date)

Date checked: ________	By:________
Date checked: ________	By:________
Date checked: ________	By:________

ABC of NC
Immunization Tracking Record

Medical Exemption: __________

Child's Name ______________________________ **DOB -** ______________ **Religious Exemption:** __________

Diphtheria, tetanus, pertussis (5 doses)					
Dose 1 By 7 months	Dose 2 By 7 months	Dose 3 By 7 months	Dose 4 By 19 months	Dose 5 On or after 4th birthday but before entering Kindergarten **If the fourth dose was administered on or before the fourth birthday, the fifth dose is not required.*	Dose 6 (12 year old dose) *A booster dose of tetanus/diptherial pertussis vaccine is required for individualswho have not previously received it and are enteering 7th grade or by 12 years of age, whichever comes first.
Date:	Date:	Date:	Date:	Date:	Date:

Polio (4 doses)			
Dose 1 By 5 months	Dose 2 By 5 months	Dose 3 By 19 months	Dose 4 On or after the 4th birthday and before entering school for the first time.
Date:	Date:	Date:	Date:

Measles (2 doses) - An individual who has documented laboratory results of a protective antibody titer against measles is not required to receive vaccine.	
Dose 1 12 - 16 months	Dose 2 Before entering kindergarten
Date:	Date:

Mumps (2 doses) - An individual who has documented laboratory results of a protective antibody titer against mumps is not required to receive vaccine.	
Dose 1 12 - 16 months	Dose 2 Before entering kindergarten
Date:	Date:

Rubella (1 dose) - An individual who has documented laboratory results of a protective antibody titer against rubella is not required to receive vaccine.
Dose 1 12 - 16 months
Date:

Hepatitis B		
Dose 1 By 3 months	Dose 2 By 5 months	Dose 3 By 19 months
Date:	Date:	Date:

Varicella (2 doses) - Vaccination is required unless documentation of diesease history is provided by a health care provider.	
Dose 1	Dose 2 (Before entering school for the first time)
Date:	Date:

All immunization records and/or exemptions must be attached to this form.

ABC Form # 0115/070615

Haemophilus influenzae type b (Hib) *			
Option 1 - 4 doses			
Dose 1 (HbOC)	Dose 2 (HbOC)	Dose 3 (HbOC)	Dose 4 (any type)
By 7 months	By 7 months	By 7 months	12 -16 months
Date:	Date:	Date:	Date:
Option 2 - 3 doses			
Dose 1 (PRP-OMP)	Dose 2 (PRP-OMP)	Dose 3 (any type)	
By 7 months	By 7 months	12 - 16 months	
Date:	Date:	Date:	
Option 3 - 2 doses	*For persons who receive the first dose of Hib between 12- 15 months of age*		
Dose 1	Dose 2		
12 -15 months	Not specified		
Date:	Date:		

Option 4 - 1 dose	*For persons who receive the first dose of Hib on or after 15 months of age*
Dose 1	
After 15 months	
Date:	
Option 5	*No vaccine required once a child is past his/her 5th birthday*

Note - Due to the shortage of Hib vaccine caused by manufacturing issues, the requirement for a booster dose of Hib vaccine on or after the age of 12 months has been temporarily suspended, until further notice. (1/18/08)

Meningococcal conjugate vaccine (MCV) **If the first dose is administered after the 16th birthday, the booster dose is not required.*			
Dose 1		Dose 2	
Before 7th grade or 12 years of age, whichever comes first		For individuals entering 12th grade or 17 years of age (beginning 08/01/20)*	
Date:		Date:	

There are two exemptions to required immunizations:

1) Medical Exemptions - An exemption is permitted for medical reasons when a physician determines that an immunization is or may be harmful to a student for a specific reason. Valid medical exemptions must be written and signed by a physician licensed to practice medicine in North Carolina. The medical exemption must correspond to those medical contraindications specified in the N.C. Immunization Rules or an approved Rules' exception approved by the State Health Director. These physician statements must be maintained in the student's permanent record and at minimum must indicate the following - basis of the exemption; specific vaccine(s) the child should not receive; and length of time the exemption will apply for the child.

2) Religious Exemptions - Parent(s), guardian or person in loco parentis who have a bona fide religious objection to immunization requirements must place a signed statement on file in the student's permanent record. An objection based upon a "scientific" belief (i.e. a foreign substance or chemical may be harmful) or non-religious personal belief or philosophy (i.e. clean living, fresh air, pure water) is **not considered to be a religious exemption and is not allowed under North Carolina law**.

A written statement must be maintained in the student's record containing, at a minimum, the following - student's name; parent(s), guardian's or person in loco parentis statement of bona fide religious objection; and parent(s), guardian or person in loco parentis signature and date signed. (If a student is at least 18 years old, his/her statement and signature are required.)

There is no form for requesting religious exemptions in North Carolina. To claim a religious exemption, the parent or person requesting the exemption must write a statement of their religious objection to immunization, including the name and date of birth of the person for whom the exemption is being requested. This statement would then be provided to schools, child care programs, camps, etc. in place of an immunization record. If a family is requesting a religious exemption for more than one child, a separate statement should be prepared for each child. Statements of religious objection to immunization do not need to be notarized or prepared by an attorney. They do not need to be submitted to the state for review or approval.

ABC OF NC CHILD DEVELOPMENT CENTER
HEALTH ASSESSMENT REPORT

HEALTH CARE PROVIDER COMPLETE

Date of Health Assessment:_______/ _______/ _______

The health assessment must be conducted by a physician licensed to practice medicine, a physician's assistant as defined by General Statute 90- 18, a certified nurse practitioner, or a public health nurse meeting the state standards for Health Check Services.

Pertinent Illnesses, Risks of Developmental Problems: (Please check all that apply)

___ Allergy
___ Anemia
___ Asthma
___ Attention/ Learning
___ Bleeding Problems
___ Cancer/ Leukemia
___ Cerebral Palsy
___ Cystic Fibrosis
___ Dental Problems
___ Diabetes
___ Emotional/ Behavioral
___ Encopresis
___Enuresis (Daytime)
___ Genetic Disorders
___ Heart Problems
___ Hearing Problems
___ Kidney Problems
___ Lead Exposure/ Poisoning
___ Obesity
___ Orthopedic Problems
___ Prematurity (<32 weeks)
___ Seizures/ Convulsions
___ Sickle Cell Anemia
___ Speech/ Language
___ Tuberculosis
___Vision Problems
___None

Physical Examination

Weight: ___________ lbs.

Height: ______ft. ______in.

Body Mass Index (BMI)-for age:____
___ Normal (5%ile- <85%ile)
___ Underweight (<5%ile)
___ At-Risk (85%ile- <95%ile)
___ Overweight (95%ile)

Blood Pressure: _______/_______

Comments: ________________________________
____

	Normal	Abnormal
HEENT	____	____
Lungs	____	____
Cardiac	____	____
Abdomen	____	____
Neurological	____	____
Back/ Extremities	____	____
Genital	____	____
Skin	____	____

Health Care Professional's Certification

I certify that the information on this form is accurate and complete to the best of my knowledge.

Provider's Name: ____
Provider's Signature:_____________________________________
Practice/ Clinic Name: ____________________________________
Practice/ Clinic Address: __________________________________
Practice/ Clinic City, State, Zip: ____________________________
Practice/ Clinic Phone: ______________________ Fax: ________________

Provider's Stamp Here

ABC OF NC CHILD DEVELOPMENT CENTER
HEALTH ASSESSMENT REPORT

PARENT COMPLETE

Please Print Clearly- See other side for more required information

Child's Name: ______________________________ ____________________ ______________________
(Last) (First) (Middle)

Birth date: ____/_____/ 20 ____ (mm/dd/yyyy)

Address: _____________________________ City: __________________ State: __________ Zip: ________

Parent/ Guardian Name: ____ Phone: ______________________

Email Address: ____

Medical History

1. Is child allergic to anything? No _____ Yes _____ If yes, what?
   ____
2. Is child currently under a doctor's care? No_____ Yes _____ If yes, for what reason?
   ____
3. Is the child on any continuous medication? No _____ Yes _____ If yes, what?
   ____
4. Any previous hospitalizations or operations? No _____ Yes _____ If yes, when and for what?
   ____
5. Any history of significant previous diseases or recurrent illness? No _____ Yes _____ If yes, please describe: ____
6. Does the child have any physical disabilities? No _____ Yes _____ If yes, please describe:
   ____

Please attach any additional pertinent information regarding your child's medical history.

Parental Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and allow the Department of Health and Human Services to collect and analyze information from this form to better understand health needs of children in NC.

Signature: ____ **Date:** _____________

HEALTH CARE PROVIDER COMPLETE

Recommendations to School Personnel Based on Health Assessment

1. Does this child take any medications? No_____ Yes _____ If yes, what?
   1.________________________________ 3. ____
   2. ________________________________ 4. ____

2. Does this child have any allergies? No _____ Yes _____

Food: _________________________________ Insect: ___________________________________

Medicine: ______________________________ Other: __________________________________

Type of allergic reaction: ___ Anaphylaxis ___ Local reaction

Response required: ___ Epinephrine Auto-Injector ___ Other: ____________________ None: ____

ABC of NC

Medication Administration Policy

ABC of NC discourages the use and administration of medication at our center but realizes it may be sometimes necessary for the health of the client. All medications and medical procedures which may be taken or given outside program hours without adversely affecting the health of the client should not be administered at the center during program hours. Reasonable efforts should be made by the parent/guardian to obtain permission from the child's health care provider to adjust the dosages of prescribed medication so such may be provided at home before and/or after program hours.

ABC of NC authorizes staff to administer prescription medications, over the counter medications, and dietary supplements, upon receipt of the written authorization of the health care provider and the written authorization of the client's parent/guardian(s).

Prescription medication shall be placed in a prescription container indicating the child's name, the name of the medication, the unit of the dosage to be given, the number of dosage units, the time the medication is to be given, and how it is to be administered. (It is recommended the parent ask the pharmacist to provide 2 properly labeled containers- one for home and one for the center).

Over the counter medication shall be placed in the original container labeled with the child's name, the name of the medication, the dosage to be given and the time and method of administration.

Dietary supplements must be pre-measured by the parent and include specific written instructions by the parent, doctor, and/or nutritionist.

Please initial below:

________ I request a paper copy of the medication administration policy.

________ I declined a paper copy of the medication administration policy.

I have read and understand ABC of NC's medication administration policy and agree to abide by its guidelines.

____ ________________

Signature of Parent/Guardian Date

____ ________________

Signature of ABC of NC Witness Date

Photo/Video Release

ABC of NC

Client's Name: ______________________________________ **Date of Birth:** __________________

Print Client's Name

I understand that photographs and/or videos may be taken as part of my child's client record and are the property of ABC of NC Child Development Center (ABC of NC). I understand that if I wish for my child's photos/videos to be used for additional purposes (e.g. training, marketing, etc.), I must give consent below. I also understand any consent granted is effective from the date of signature until I provide written notice of revocation. Any renovation of permission will be effect for materials produced beyond the date of the revocation, but will not apply to materials produced by ABC of NC prior to the revocation of permission.

ACCEPT PHOTO/VIDEO CONSENT:

_______ I give permission for my child's photo/videos and client information/work to be used **INTERNALLY** (e.g. display within the center, group photos, other clients' communication devices, staff training, etc.)

_______ I give permission for my child's photo/videos and client information/work to be used **EXTERNALLY** (e.g. collaborating agencies, community trainings, social media, website, advertising, ABC of NC newsletter, solicitations etc.)

DECLINE PHOTO/VIDEO CONSENT:

_______I do **NOT** give permission for my child's photos/videos/etc. to be used for purposes other than client records.

____________________________________ ____________________________

Signature of Parent/Guardian of Client *Date*

ABC of NC

Client Grievances

ABC of NC supports open communication; therefore, clients should feel free to ask questions or express concerns at any time. Most issues can be resolved with personal communication. ABC of NC provides a confidential, legal, and fair procedure for clients to issue a grievance against ABC of NC staff and for these grievances to be resolved as soon as possible.

Grievance process:

- If a parent/caregiver has a complaint or concern, the first action is to speak with a direct-care provider/supervisor (i.e. program supervisors, counselor, practice manager, etc.).
- If the concern is not satisfactorily resolved, a formal written complaint can be submitted directly to the executive director. The executive director will make every attempt to resolve the situation with the client.
- If the client is not satisfied with the executive director's resolution, the client may file a formal written complaint to the chair of the board of directors who will attempt to resolve the issue. The Client Rights Committee may be asked to convene and will attempt to address and make every effort to resolve the issue to the client's satisfaction.
- Clients always have the choice of leaving the program if they are not satisfied with ABC of NC's resolution regarding the issue/complaint.
- In cases of suspected abuse, clients have the right to contact the Department of Social Services.
- Clients have the right to contact the North Carolina Governor's Advocacy Council at any time regarding their complaint or concerns.
- Other agencies where complaints can be filed include:
    - NC Division of Health Services Regulations (DHHS)
      https://info.ncdhhs.gov/dhsr/ciu/complaintintake.html; 800-624-3004
    - NC Psychology Board
      https://www.ncpsychologyboard.org/; 828-262-2258
    - NC Board of Licensed Clinical Mental Health Counselors
      www.ncblpc.org; 336-217-6007
    - NC Behavior Analyst Licensure Board
      www.ncbehavioranalystboard.org
    - NC Division of Non-Public Education
      https://ncadmin.nc.gov/about-doa/division-non-public-education; 984-236-0110
    - Behavior Analyst Certification Board
      www.bacb.com
    - Disability Rights NC
      https://disabilityrightsnc.org/; 877-235-4210

Please initial below:

______ I requested a paper copy of this grievance policy.

______ I declined a paper copy of this grievance policy.

ABC of NC

Electronic Communication Policy

Email offers an easy and convenient way for therapist and client to communicate, but it can also introduce unique challenges into the therapist-client relationship. Below are some guidelines for contacting ABC of NC Child Development Center using email:

- For emergencies, consult an emergency room or mobile crisis. Do **NOT** use email for emergencies!
- Email is not a substitute for an appointment. If you need an appointment, please schedule a session.
- Appropriate use of email can include referrals and appointment scheduling requests.
- Email should **NOT** be used to communicate sensitive medical information such as: information regarding sexually transmitted diseases, AIDS/HIV, Mental Health, Developmental Disabilities, and/or Substance Abuse.
- Email is **NOT** confidential. Be aware that if you send emails from your work, your employer may be able to read your email.
- Email is part of your medical record.
- Either party can revoke permission to use the email system at any time.

Texting can also introduce some of the same challenges as email:

- Like email, texting is **NOT** a substitute for an appointment. If you need an appointment, please schedule a session.
- Because phones can be lost or stolen, it is imperative that you do not communicate information of a sensitive nature over text.
- Appropriate use of text is limited to appointment confirmations or appointment/ call requests.
- Clients should not text ABC of NC staff.
- ABC of NC may use texts or automated phone calls for appointment reminders

Please initial below:

______ I have read the above information and understand the limitations of electronic communication. I understand that ABC of NC may not be able to communicate with me electronically if there are concerns regarding confidentiality.

Please initial the appropriate lines. Put N/A or leave blank if you do not permit this form of electronic communication.

__________ It is permissible for ABC of NC to contact me via email regarding scheduling.

__________ It is permissible for ABC of NC to contact me via text regarding scheduling.

__________ It is permissible for ABC of NC to forward your information about services, special programs, funding opportunities, special events, and the ABC of NC Newsletter.

Client Name: ____

Client or Guardian Signature: ________________________________ Date: ______________________

Email Address: ____ Cell Phone: __________________

Preferred Contact Method: __________________________________ OK to leave a message? Yes No

ABC of NC

HIPAA (Health Insurance Portability and Accountability Act) Consent and Notice of Security and Privacy Practices
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client information will be maintained by **ABC of NC Child Development Center** as described the Notice of Privacy Practices contained in the Compliance Program and in compliance with federal and state regulation. A copy of the Notice of Privacy Practices is available for review at time of intake, any subsequent appointments, or can be requested by contacting ABC of NC at 336-251-1180.

ABC of NC Child Development Center reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and, in general, for continuity of care. Disclosure of information may occur with a consent unless it is an emergency situation or for other exceptions as detailed in the General Statute or in 45 CFR 164.512 of HIPAA. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it with a signed release of information form.

We reserve the right to:

1. Call you to remind you of your next appointment and/or leave information on your voicemail.
2. Text or email you appointment reminders if your consent is on file (electronic communication policy).

If there is anyone that you would like us to share your health information with, other than a provider, agency, and/or school, please list the names below and circle what type of consents you wish to provide.

Name:	Scheduling	Billing/ Payments	Daily/ Treatment Progress	Interventions	Diagnostic Considerations
Name:	Scheduling	Billing/ Payments	Daily/ Treatment Progress	Interventions	Diagnostic Considerations

I have had the opportunity to read, understand, and ask questions about the Notice of Privacy Practices.

___________ I decline to keep the notice ______________ I have kept the notice

____ ____________________

Client (child) Name Client Date of Birth

____ ____________________

Client Signature (if over age 13) Date

____ ____________________

Parent/Guardian Signature Date

____ ____________________

Witness Signature Date

ABC of NC

First Aid Treatment Consent

I hereby give permission for my child, ________________________________, to receive first aid during program hours using supplies from a basic first aid kit.

Please list any allergies your child has to basic first aid items:

____

____

____

I understand that it is the responsibility of the parent/guardian to maintain communication with the staff regarding any changes in the client's condition, medication, and other health needs at the center. I do hereby release ABC of NC staff from any and all damages for injuries or illness occurring from the administration of traditional first aid. To the best of my knowledge, all of the above information is accurate and complete. I hereby authorize ABC of NC to share this information with staff as necessary for the safety and welfare of my child. Any consent granted is effective from the date of the signature until the parent/ guardian provides written notice of revocation.

____ ____________________

Parent/Guardian Signature Date

ABC of NC

Emergency Contact/Medical History/Treatment Release

Emergency Contact Information:

Client's Last Name:	Client's First Name:	Client's Middle Name:

Parent/Guardian A:

Last Name:	First Name:	Middle Name:
Cell Phone #:	Home Phone #:	Work Phone #:

Parent/Guardian B:

Last Name:	First Name:	Middle Name:
Cell Phone #:	Home Phone #:	Work Phone #:

Alternate Emergency Contact:

Last Name:	First Name:	Middle Name:
Cell Phone #:	Home Phone #:	Work Phone #:

Client Medical History

Client's Last Name:	Client's First Name:	Client's Middle Name:	
Date of Birth:	Height:	Weight:	Social Security #:
Allergies:			
Current treatments/medications:			
Special health needs:			
Any prior hospitalizations, surgeries, broken bones, recurring/significant illnesses, etc.:			

Circle all of the following diseases and/or chronic conditions the child has had:

Chicken Pox	Asthma	Hearing Problems	Respiratory Infections
Infectious Hepatitis	Diabetes	Vision Problems	Urinary Tract Infections
Scarlet Fever	Epilepsy	Convulsions	Ear Infections

Physician Name:	**Physician Phone #:**	**Physician Fax #:**
Dentist Name:	**Dentist Phone #:**	**Local Hospital Preference:**
Medical Insurance Carrier:	**Medical Insurance Policy Holder's Name:**	**Medical Insurance Policy #:**

Treatment Release

I certify that I am the legal parent/guardian of the above named client, who attends ABC of NC Child Development Center, and that, in the case of emergency, I give consent for ABC of NC to contact the emergency contacts and medical personnel listed above, and I give consent for emergency medical treatment including: 1) administration of any emergency treatment deemed necessary by any licensed physician, dentist or other health-care provider; and 2) transfer of the client to any hospital reasonably accessible. This authorization does not cover invasive surgery upon the client unless the medical opinions of two licensed physicians concurring on the necessity of such surgery are obtained prior to the performance of such surgery. I understand that this consent is granted until I provide written revocation of such consent.

____ __________________________

Signature of Legal Parent/Guardian Date

ABC of NC

Confidentiality, Privacy, and HIPAA Practices

1. ABC of NC is committed to treating and using health information about its clients responsibly, and we are required by the Heath Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") to maintain the privacy and security of client health information.
2. All clients receive written notification and must sign acknowledgement of receipt of ABC of NC confidentiality, privacy, and HIPAA practices, including, but not limited to:
    a. How ABC of NC may use and disclose health information
    b. Individual rights regarding the client's health record
    c. ABC of NC's legal duty regarding the client's health record
    d. Contact information for the ABC of NC privacy officer
    e. Complaint information regarding confidentiality/privacy violations
3. ABC of NC's Notice of Privacy Practices applies to all protected health information as defined by federal law, and includes, among other things, information about symptoms, test results, diagnosis, and treatment as well as payment, billing, and insurance information. This Notice tells clients how The Autism Clinic may use and disclose health information, client rights as they relate to health information, and how to file a complaint if a client believes her/his privacy rights have been violated. For your convenience, the Notice of Privacy Practices is located in the School Lobby, Clinic Lobby and the Psychology suite lobby for your review. If you prefer your own copy, please request a copy from the Clinical Receptionist.
4. ABC of NC may use and disclose client health information for a variety of important purposes:
    a. We may use and disclose client health information without client authorization for the following purposes:
        i. Treatment: We may use and disclose client health information to provide the client with medical treatment or services. For example, psychologists, therapists, and other members of the treatment team will record information in the medical record and use it to determine the most appropriate course of care. We may also disclose health information to other health care providers who are participating in the client's treatment and to pharmacists filling prescriptions.
        ii. Payment: We may use and disclose client health information for payment purposes. For example, we may disclose health information to obtain payment from the client's insurance company for the client's care.
        iii. Health care operations: We may use and disclose client health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of client cases.
        iv. Research and planning: The Secretary of DHHS may require information that does not identify clients from state and area facilities for purposes of preparing statistical reports of activities and services. The Secretary may have access to confidential information from

private or public agencies for purposes of research and evaluation; no confidential information shall be further disclosed. A facility may disclose confidential information to persons responsible for conducting general research or clinical, financial, or administrative audits if there is a justifiable documented need for this information. A person receiving this information may not directly or indirectly identify any client in any report of the research or audit or otherwise disclose client identity in any way.

v. Required by law: We may use or disclose client health information when such use or disclosure is required by federal, state, or local law and the use or disclosure complies with and is limited to the relevant requirements of such law.

vi. Public health activities: We may disclose client health information, including, but not limited to, vital statistics (including births and deaths), disease-related data, and information related to recalls of dangerous products, to public health authorities for public health activities.

vii. Abuse, neglect or domestic violence: We may disclose client health information to a government authority when the disclosure relates to victims of domestic violence, abuse, or neglect, or the neglect or abuse of a child or an adult who is physically or mentally incapacitated.

viii. Internal client advocate (a client advocate who is employed by the facility or has a written contractual agreement with DHHS or with the facility to provide monitoring and advocacy services to clients in the facility in which the client is receiving services):

1. We may give access to routine reports and other confidential information necessary to fulfill the advocate’s monitoring and advocacy functions. In this role, the advocate may disclose confidential information received to the client involved, to the legally responsible person, to the director of the facility or a designee, to other individuals within the facility who are involved in the treatment or habilitation of the client, or to the Secretary in accordance with the rules of the Commission.
2. Any further disclosure shall require the written consent of the client and her/his legally responsible person.

ix. Next of kin: Information shall be provided to the next of kin or other family member, who has a legitimate role in the therapeutic services offered, or other person designated by the client or her/his legally responsible person in accordance with the following provisions:

1. Upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client or his legally responsible person, the responsible professional shall provide the next of kin or other family member or the designee with notification of the client's diagnosis, the prognosis, the medications prescribed, the dosage of the medications prescribed, the side effects of the medications prescribed, if any, and the progress of the client, provided that the client or his legally responsible

person has consented in writing, or the client has consented orally in the presence of a witness selected by the client, prior to the release of this information. Both the client's or the legally responsible person's consent and the release of this information shall be documented in the client's medical record. This consent shall be valid for a specified length of time only and is subject to revocation by the consenting individual.

2. Upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client or his legally responsible person, the responsible professional shall provide the next of kin, or family member, or the designee, notification of the client's admission to the facility, transfer to another facility, decision to leave the facility against medical advice, discharge from the facility, and referrals and appointment information for treatment after discharge, after notification to the client that this information has been requested.
3. In response to a written request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client, for additional information not provided for in subsections above, and when such written request identifies the intended use for this information, the responsible professional shall, in a timely manner:
    a. Provide the information requested based upon the responsible professional's determination that providing this information will be to the client's therapeutic benefit, and provided that the client or his legally responsible person has consented in writing to the release of the information requested; or
    b. Refuse to provide the information requested based upon the responsible professional's determination that providing this information will be detrimental to the therapeutic relationship between client and professional; or
    c. Refuse to provide the information requested based upon the responsible professional's determination that the next of kin or family member or designee does not have a legitimate need for the information requested.

x. Health oversight: We may use or disclose client health information to a health oversight agency for oversight activities authorized by law. For example, we may disclose client health information to assist in investigations and audits, eligibility for government programs like Medicare and Medicaid, and similar oversight activities.

xi. Judicial and administrative proceedings: We may disclose client health information in response to an appropriate subpoena or other lawful request for information in the course of legal proceedings, or pursuant to a court order.

xii. Law enforcement purposes: Subject to certain restrictions, we may disclose client health information to law enforcement officials. For example, we may disclose client health information to comply with laws that require the reporting of certain wounds or injuries or to assist law enforcement in identifying or locating a suspect, fugitive, or missing person.

xiii. Coroners/medical examiners: We may disclose client health information to a coroner or medical examiner for the purpose of identifying a decedent, determining cause of death, or for other purposes to enable these parties to perform their duties. We may also disclose client health information to a funeral director as necessary to carry out his/her duties.

xiv. Organ donation: We may use or disclose client health information to organ procurement organizations when the use or disclosure relates to organ, eye, or tissue donation and transplantation.

xv. Research: Subject to certain restrictions, we may use or disclose client health information for medical research.

xvi. Serious threat to health or safety: We may use or disclose client health information when necessary to prevent a serious threat to the client's health and safety or the health and safety of the public or another person. Any disclosure, however, may only be to someone able to help prevent the threat.

xvii. Military and special government functions: If a client is a member or a veteran of the armed forces, we may use or disclose client health information as required by military command authorities. We may also disclose client health information for national security, intelligence, or similar purposes.

xviii. Inmates: If the client is an inmate of a correctional institution or otherwise in the custody of a law enforcement official, we may disclose client health information to the correctional institution or law enforcement official when necessary for the correctional institution to provide the client with health care; to protect the client's health and safety or the health and safety of others; or for law enforcement on the premises of, or the administration and maintenance of, the correctional institution.

xix. Workers compensation: We may disclose client health information to comply with workers compensation laws or similar programs providing benefits for work-related injuries or illness.

xx. Limited marketing: We may use or disclose client health information when the use or disclosure is permitted for marketing purposes, such as when a marketing communication occurs in a face-to-face meeting with the client or concerns promotional gifts of a nominal value.

xxi. Appointment reminders: We may use client health information to contact the client with appointment reminders. We may also use client health information to provide information to the client about treatment alternatives or other health-related benefits and services that may be of interest to the client.

xxii. Business associates: We may use or disclose client health information when the use or disclosure is necessary for our business associates, such as consultants, lawyers, and billing companies, to provide services to, or provide business functions for, ABC of NC. To protect client health information, we require business associates to sign specialized agreements designed to safeguard client health information in their hands.

5. We may use and disclose client health information for the following purposes only after giving the client an opportunity to agree or to object to the use or disclosure and the client has either agreed or not objected to the use or disclosure:
    a. Involvement in care: We may disclose client health information to family members, other relatives, or friends if the information is directly relevant to the family's or friend's involvement in the client's care or payment for that care, and the client has either agreed to the disclosure or has been given an opportunity to object and has not objected to the registration clerk or the Privacy Officer. If the client is not present or able to agree or object, or if there is an emergency situation, we may disclose client health information to the family or friends if we determine the disclosure is in the client's best interest. We may also disclose client health information to notify, or assist in the notification of, a family member, relative, friend or other person identified by the client of your location, general condition, or death.
    b. Disaster relief: We may share client health information with a public or private agency (e.g., American Red Cross) for disaster relief purposes. Even if the client objects, we may still share client health information in emergency circumstances.
    c. External client advocate (a client advocate acting on behalf of a particular client with the written consent and authorization – in the case of a client who is an adult and who has not been adjudicated incompetent; or b) in the case of any other client, of the client and her/his legally responsible person)
        i. An external client advocate may have access to confidential information only upon the written consent of the client and her/his legally responsible person.
        ii. In this role, the external client advocate may use the information only as authorized by the client and her/his legally responsible person.
6. In any situations other than those described above, we will ask for the client's written authorization before using or disclosing health information. If the client chooses to sign an authorization to allow us to use and disclose health information, the client can later revoke that authorization to stop any future uses and disclosures by contacting the Privacy Officer. However, the client cannot revoke authorization for uses and disclosures that we have made in reliance upon such authorization.
    a. A clear and legible photocopy of a consent for release of information shall be considered to be as valid as the original.
    b. The following persons may sign consent for release of confidential information: a competent adult client or the client's legally responsible person.
    c. Prior to obtaining a consent for release of information, an employee must inform the client or her/his legally responsible person that the provision of

ABC of NC

Receipt of Parent Handbook

Each new client will receive a copy of the current Parent Handbook, which outlines the policies and procedures of ABC of NC. Parents/guardians are required to sign the "Receipt of Parent Handbook" form acknowledging that they have read, understand, and agree to the policies and procedures therein.

____ ________________
Client Full Name Date of Birth

____
Parent (A) Printed Name

____ ________________
Parent (A) Signature Date

____
Parent (B) Printed Name

____ ________________
Parent (B) Signature Date