4425 Plano Pkwy Suite 403
Carrollton, TX 75010

Office: (469) 900-8063
Fax: (214) 291-5993
www.spectrumofgrace.org
info@spectrumofgrace.org

PROSPECTIVE CLIENT

SUBJECT: ABA SERVICES FOR YOUR CHILD

Dear Prospective Client,

Thank you for your interest in our company. Please complete the Terms and Policies form as well as the Client Registration packet to provide sufficient information to assess how we can be of service. Additionally, there is a Client Referral Form that can be completed by your Child's diagnosing professional, if applicable. Once these documents are received, we can begin to assess an appropriate path towards beginning treatment.

Once you have completed the documents, you can email them to adrenastreetz@spectrumofgrace.org, together with a copy of your insurance card(s), front and back and a prescription for ABA Services, if available. I am available by phone or email should you have any questions.

Thank you again for your interest in our services and we look forward to working with your family.

Sincerely,

Adrena Streetz, M.A, BCBA, LBA, Executive Director

Adrena Streetz, M.A. BCBA, LBA

Parent Guidelines

Your cooperation on the following is greatly appreciated to assist us in working with your child effectively and efficiently:

- A parent or responsible adult must be in the home during therapy sessions.
- Your child should be dressed and fed prior to therapist arrival unless these skills are being addressed in the program.
- For all in home sessions the area being used for therapy must be a comfortable temperature, well-lit and relatively free of distractions. It is important that we are able to conduct the session in a professional manner with materials ready and limited access to competing reinforcers (i.e. toys that are not used during the therapy session).
- The therapist must wait 15 minutes if child is not there at the therapy time and then is permitted to leave.
- The therapist will call the family if they are going to arrive more than 5 minutes late.
- A therapist cannot change appointment times without agreement with the family.
- If your family is planning an extended vacation (more than 2 weeks), please inform the BCBA and supervisor. We will continue to reserve the spot for your child, but cannot guarantee that your child will work with the same therapist.
- In case of an accident or unusual incident, the therapist should complete an incident form and family and BCBA will be informed within 1 working day.
- The therapist is NOT allowed to take a child in their automobile.
- Parents and consultants/therapists should be respectful and courteous to each other. Open communication between parents and consultants/therapists is essential to the establishment of a successful program for the child. If there are any problems or concerns, please contact the Chief Clinical Officer immediately.
- Please understand that all information shared is HIPPA protected, it is essential that every Spectrum of Grace, LLC employee respects and maintains each client's right to confidentiality regarding his or her treatment and all personal information. All HIPPA laws apply. Please do not ask about another client's program or treatment, as this information will not be discussed and could possibly lead to the dismissal of your child from the program.
- Sickness. Please notify the therapist, as much in advance as possible, at least the night, before the scheduled session if you know that your child (or other children in your home) will not be able to participate in the program the next day due to illness.
- Parents are asked to use the same guidelines used in a school – if a child (or sibling) is too sick to attend school, he or she is too sick to participate in his/her therapy session. Therapy will resume as soon as the child's doctor clears him/her of being contagious or the remedy is completed. If a therapist arrives at the home and the child is sick, the therapist will not be able to work with your child.

____ Parent/Guardian Initials

Parent/Client Responsibilities

In order to ensure that treatment is effective, it is imperative that the client/client's family must always remain honest and disclose all information that may assist or impact the treatment process. I will ask you questions which pertain to the treatment process, as well as ask you to attend to the data in order to determine what behaviors need to be addressed and if the behavior plan is successful. I expect complete honesty on your end and that you provide me with information openly and truthfully throughout this process. I will need a list of the medication currently prescribed, along with mental health and medical conditions; however, this information will remain confidential. Behavior analysis therapy most often does not mix well with non-evidence-based treatments. If your child is currently involved with any non-evidence-based treatments, please inform me from the onset of services along with any other therapies your child is involved in with other therapists. If at any point during our treatment your child begins new therapies, please inform immediately so that we can discuss the implications.

I expect that if at any point you need to cancel or reschedule an appointment, please notify me as soon as you are aware of the change. If I do not receive 24-hour notice of your cancellation or if you fail to show for an appointment, you may be subject to the full amount due for the appointment without make up.

Family's Role in Therapy

Spectrum of Grace, LLC, strives for excellence in its ABA program and an integral component to achieve that goal is family involvement. Spectrum of Grace, LLC requires caregivers carry over the therapy being implemented and record data for specific programs as outlined in the client treatment plan. If the Client/Family refuses involvement in the treatment plan, as a last resort services may be suspended or terminated based on the severity of the lack of involvement. Spectrum of Grace, LLC wants to help all clients we interact with but without the client/family involvement our treatment plans will not be as effective as possible.

No one knows your child better than you (the parent) and you are ultimately the one who cares the most and are most affected by your child's challenges and strengths. As a Behavior Analyst, my goal is to ultimately assist you and your child in being successful in finding proper coping mechanisms which create happiness and wellbeing. With your input, we can help you discover what is maintaining your child's problem behaviors (including the symptoms of autism), discover more appropriate replacement behaviors, and help us teach your child new functional skills and behavior. We can further help you acquire new behaviors to improve your skill level. You will be consulted at each step of the process. We will ask you about your goals, and we will explain our assessment and the results of our assessments in plain English. We will describe our plan for intervention or treatment and ask for your approval of the plan.

Because you spend a great deal of time with your child, our goal is to teach you to use that time to generalize the teaching goals into everyday living situations. Watch and learn from your therapy providers and access as much parent training as you can. Though you are not expected to be a therapist to your child, your involvement will optimize your child's therapy.

____ Parent/Guardian Initials

IN-HOME THERAPY REQUIREMENTS

- Provide an area that is well-lighted and void of to many visual and audio distractions

- Provide an area air-conditioned or heated for the comfort of your child

- Provide table and chairs for your child to learn

- Provide necessary, age-appropriate learning toys (puzzles, figurines, games, etc.) and preferred items/edibles to use as reinforces.

- Provide a clean, illness, and disease-free environment

- Provide assistance and information where necessary to avoid injuries from aggression due to the behavioral excesses your child may have.

SESSION MATERIALS

If your child receives in home therapy, Spectrum of Grace, LLC may purchase materials to help the sessions run smoothly and so that providers have all they need to teach your child. These supplies are the property of Spectrum of Grace and you will be required to return them to our office location within 5-business days or reimbursement of the items that were lost will be due immediately. In addition, we encourage all families to set a budget to purchase items and reinforcers the client frequently uses during sessions.

Scheduling and Sessions

Each client will have a Board-Certified Behavior Analyst as the lead supervisor for their treatment. A Behavior Technician will provide direct 1:1 therapy in the designated setting. Each Behavior Technician works under the guidance of the Behavior Analyst and undergoes training and experience providing services to children with Autism. Sessions for ABA services are usually scheduled in two-to-three-hour blocks. A parent/ legal guardian or adult over the age of 18 is required to be present and available during in home therapy sessions.

Except in cases of emergency, 24 hours' notice is required for all cancelled appointments. We request that families give us at least two weeks' notice on significant changes in their plans for in-home ABA sessions scheduling to facilitate consistency in service delivery.

The universal standard for therapy that the last 15 minutes of each session is devoted to data collection, note writing, material preparation/organization for the following session and discussion of session with the parent.

_____ Parent/Guardian Initials

Service Agreement and Consent Form

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

Consent for Services

Client Name: ________________________________ DOB: _____________________ I, ___________________________, agree to have my child ______________________ evaluated/treated through Spectrum of Grace, LLC. I understand that these services are based on an applied behavior analysis (ABA) model and will be provided by a professional trained in ABA. I understand that state laws may require that confidentiality be broken under certain circumstances, specifically, if I am judged by the behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected child abuse.
I also understand that Spectrum of Grace, LLC specializes in the evaluation and treatment of problem behaviors as well as skill acquisition, and if Spectrum of Grace, LLC is unable to meet my particular needs, I will be referred to an appropriate agency or individual.

_____ Parent/Guardian Initials

Services and Discharge

Spectrum of Grace, LLC offers a full-service ABA program. To determine the program needed for a client an assessment is completed to determine whether a client would benefit from our services. After it has been determined that our services are needed, a BCBA is appointed as the team leader and develops a treatment plan based on the findings of the assessment. The treatment plan includes general and specific goals with time frames for completion. The treatment plan also includes a scheduled reassessment generally six months from the time the treatment plan is developed. The treatment plan is then implemented by the BCBA who supervises Behavior Technicians on proper implantation of the treatment plan.
As needed, the program is adjusted by a BCBA to accommodate the client's progress. If the treatment plan is over challenging the plan will be modified with lower intensity goals. As the client advances through the program more challenging goals can be added to the plan.
If after adjusting the treatment plan and following the updated plan we may determine our services is not the proper treatment for the client. If such a determination is made, we will follow our discharge and referral protocol.
Once the client has attained the level of development similar to a typical developing child, the client will be put on a maintenance program until the BCBA determines services will no longer benefit the client. Being a sudden stop in services can be detrimental to the skills acquired, the discharge from services is done over a long period of time to achieve a smooth transition.

TERMINATION OF SERVICES

You have the right to terminate our services at any time; provided, however, that in such event, the balance of our fee (reduced appropriately for services yet to be performed) shall become immediately due and payable by you or your insurance. Upon termination, failure to immediately pay for services already rendered by Spectrum of Grace, LLC constitutes breach of the Agreement. We will also have the right to terminate our services with you at any time. We further reserve the right in our discretion to terminate our services and resign our engagement in the event that any of our statements for fees and expenses remain unpaid (in whole or in part) after the due date for such statement and 10 days after we have notified you that we intend to resign if such statement is not fully paid. You expressly agree and consent to our right to terminate and resign as set forth in this paragraph.

TRANSITION OF SERVICE POLICY

A 30-day written request of termination is recommended for Spectrum of Grace, LLC to provide a transition plan individually designed for each child's needs and the needs in their environment with regards to ABA therapy being implemented. To achieve smooth transition for the child to no longer receive ABA therapy by a provider or to transition therapy implementation to the parent, collaboration between your SOG BCBA and the new provider or parent is required. Parents must understand that when services are terminated without a proper 30-day notice, the transition of ABA therapy to another service provider or to parent may have a regressive outcome for the child. New or desirable behaviors may decrease in frequency and reduced problem behaviors may increase or may not be maintained.

_____ Parent/Guardian Initials

Confidentiality, Records, and Release of Information
Services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals or agencies.

To Protect the Client or Others from Harm
If we have reason to suspect that a client or other minor is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions, which could include notifying the police, and intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

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

Miscellaneous Services
Additional Services are offered that may include, but not limited to, phone consultation, co-treatments, attendance of school meetings and IEPs, attendance of psychological evaluations, etc.

Appointments and Deposit Policy
For all assessments, a $100 non-refundable deposit is required 24 hours before first appointment to confirm and hold your appointment. The deposit will be applied to your balance due on the day of your appointment.

Except for rare emergencies, we will see you (or your child) at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitates the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you email or call our office directly and give as much notice as possible to cancel or reschedule. This will allow us to offer your time to another person. You may be charged the standard hourly rate for appointments missed or cancelled with less than 24 hours advance notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

Cancellation Policy
We ask for at least 24 hours' notice, as a courtesy if you will need to reschedule or cancel your appointment. For all assessments we are happy to reschedule your appointment and apply your deposit towards a future appointment if you give at least 24 hours' notice.
For all other appointments cancellations with less than a 24-hour notification: $50 per appointment

_____ Parent/Guardian Initials

FEES & PAYMENT

INSURANCE BILLING POLICIES

- $100 per hour- Consultation Services (case-by-case)
- $200 (flat fee)- Functional Behavior Assessment & Behavior Change Plan
- $150 per hour- Direct one to one therapy provided by BCBA
- $120 per hour- Parent Training by BCBA

To facilitate access to needed services, Spectrum of Grace LLC offers a sliding scale for families who do not have insurance, or have insurance not accepted by Spectrum of Grace LLC based on your personal circumstances. Sliding scale agreements are established per families request. Please submit a request for this directly to adrenastreetz@spectrumofgrace.org and a sliding scale fee agreement will be provided.

Invoices are billed on each Monday of the week on/before services are performed. All payments for services are due when invoices are billed no matter what day your child's appointment falls on. If payment cannot be paid, please contact the BCBA so that a payment plan can be agreed upon.

Late Payments: If the BCBA is not contacted, a $25 late fee will be assessed on the last day of each week that an invoice is not paid and will be billed using the card on file.

Payments

We accept the following forms of payment;

- Check
- Credit and Debit Cards
- HSA

Late Arrival/ Pick up Policy

A grace period of 15 minutes will be permitted for unforeseen delays that a client may encounter while traveling to our office for their appointment. If a client is more than 15 minutes late to their appointment, the appointment is subject to cancellation and therapist availability. You will be charged the cancellation fee if the appointment must be cancelled due to later arrival. If you are late to pick up your child, please call our office as soon as possible. If no notice is giving, each client picked up more than 5 minutes late of their scheduled session will be charged a $1.00 per minute late fee. Change in Fee Structure

The fee structure for all services rendered through Spectrum of Grace, LLC is subject to change. Clients will be made aware of such modifications 30 calendar days prior to the effective date of any changes.

_____ Parent/Guardian Initials

AUTHORIZATION TO BILL INSURANCE

I, ___________________________, hereby give my consent for Spectrum of Grace, LLC to bill my/my child's insurance carrier for the services rendered to my child by the above-mentioned provider. In addition, I agree to pay Spectrum of Grace, LLC any deductible or uncovered charge in accordance with my health care plan.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INSURANCE CARRIER
I understand that my express consent is required to release any health care information relating to assessment and treatment. I, _________________________________, hereby give my consent for Spectrum of Grace, LLC to release medical and other relevant information to our insurance carrier as required by my/our insurance carrier to process medical billings.

Parent/Guardian Printed Name: _________________ Date: _____________________
Parent/Guardian Signature: _________________________________

Permission to Photograph

Client's Name: _________________________ DOB: __________________

I give permission and consent for Spectrum of Grace, LLC to videotape and/or audio tape my child and/or myself during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Spectrum of Grace, LLC.
I give permission and consent for Spectrum of Grace, LLC to photograph my child and/or myself during the time my child is enrolled in services. I understand these photographs may be used in educational training presentations.

Parent/Guardian Printed Name: _________________ Date: _____________________
Parent/Guardian Signature: _________________________________

In addition to the above, I also give permission for Spectrum of Grace, LLC to use full-face photographs of my child for promotional or marketing materials.

Parent/Guardian Printed Name: _________________ Date: _____________________
Parent/Guardian Signature: _________________________________

AUTHORIZATION TO RELEASE INFORMATION

Client Name: __________________________________ DOB: ___________________

I understand this release is voluntary and applies to all programs and services operated under the supervision of Spectrum of Grace, LLC.

I hereby authorize Spectrum of Grace, LLC to (check all that apply):

____ Exchange information with ____ Release information to ____ Obtain information from

The following Organization/Individual in regard to the above-named patient:

Name of Organization/Individual: ____
Address: ____
City: ______________________________________ State: _____ Zip: ______________
Phone: ______________________________

I hereby authorize this information to be exchanged in the following manner(s):

____ Verbal only
____ Written form only
____ Both verbal and written communication

Description of information to be exchanged / released / obtained (select all that apply):

____ Education records
____ Evaluation/assessment/eligibility records
____ Medical records
____ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

Other:
____

This information is to be used for diagnostic, treatment planning and continuity of care purposes only.

This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing. From _________________(MM/DD/YYYY)
To _________________MM/DD/YYYY)

Professional Records

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

Patient's Rights

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

Contacting Us

Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends.). If you are difficult to reach, please leave your availability within the message. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms described above.

These policies have been fully explained to me and I fully and freely give my consent for service to be implemented as proposed.

______________________________ ______________________________
Client's Name Date

____
Parent/Guardian Printed Name

____
Parent/Guardian Signature

Services: Spectrum of Grace, LLC implements Applied Behavior Analysis for its services. A variety of techniques are integrated and utilized during treatment. You will be encouraged to practice various skills introduced in sessions. A treatment plan with specific goals will be explored and updated according to treatment plan schedules. Recommendations for additional treatment and/or intensive treatment may be made, if needed. **When a client is a minor under the age of 14,** parent involvement is required during all visits with the Client. Information will be limited to accommodate confidentiality with children of all ages. Family involvement is an important part of treatment. Children under the age of 18 will require a parent's signature (or legal guardian) to receive any form of treatment.

Concerns about services may be directed to Adrena Streetz, at adrenastreetz@spectrumofgrace.org

Parent/Guardian Printed Name: ______________________ Date:__________________
Parent/Guardian Signature: ____________________________________

Confidentiality Act – Abuse-Reporting Protocol

I understand all information related to the above-named client's assessment and treatment must be handled with strict confidentiality. No information related to the client, either verbal or written, will be released to other agencies or individuals without the express written consent of the client's legal guardian. By law, the rules of confidentiality do not hold under the following conditions:

1. If abuse or neglect of a minor, disabled, or elderly person is reported or suspected, the professional involved is required to report it to the Department of Children and Families for investigation.

2. If, during the course of services, the professional involved receives information that someone's life is in danger, that professional has a duty to warn the potential victim.

3.. If our records, our subcontractor records or staff testimony are subpoenaed by court order, we are required to produce requested information or appear in court to answer questions regarding the client.

SUBMITTING COMPLAINTS

If at any time, you are dissatisfied with our professional relationship, please let me know. If I am unable to resolve the issue, you can report your concerns to Behavior Analyst Certification Board, 8051 Shaffer Parkway Littleton, CO 80127 (720) 438-4321 info@bacb.com www.bacb.com

Financial Responsibility

Client Name: ________________________________ DOB: _____________________

If you are covered by an HMO or Managed Care Plan:

- The client is responsible to pay any co-payment or any portion of the charges as specified by the plan mentioned above.
- Any medical services not covered by an individual's insurance plan are the client's responsibility and payment in full is due at the time of the visit. Specific coverage issues should be addressed by the insurance company's member services department (telephone number is on the card).
- The client is responsible to ensure that any required referrals for treatment are provided to the practice at the time of the visit. Visits may be rescheduled, or the patient may be financially responsible due to the lack of the referral.
- We reserve the right to charge the completion of forms and letters. For example, insurance, or different programs, and the copying of records.
- Any outstanding balance either not paid in full or under a payment plan agreement can be transferred to an outside collection agency.

For clients who do not have insurance:

- Clients who do not have any insurance coverage are expected to pay weekly. An invoice will be sent each Monday with an expectation payment is received by the end of the day unless prior arrangements have been discussed. A sliding scale may be implemented to accommodate any financial difficulties on a case-by-case basis.
- It is important for you to make sure we are in-network, and we are currently a provider with your insurance company.
- If we are currently a provider with your insurance company, the necessary forms will be completed and submitted, and secondary insurances will be billed when applicable.

Sliding Scale Only **(please discuss with BCBA)**

I am responsible for a fee of $__200__ for an initial assessment and $______ for each direct therapy session. Sliding scale is not billable to insurance.

Parent/Guardian Printed Name ____________________ Date:___________

Parent/Guardian Signature:______________________________

Witness: ______________________________ Date: ____________

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Office: (469) 900-8063
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info@spectrumofgrace.org

Credit Card Payment Authorization

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I ________________________ authorize Spectrum of Grace LLC __________ to charge my
(Cardholder's Name) (Merchant's Name)

Credit Card indicated below for $________________ on the ________________ of
(Amount $) (day)

each ________________.
(week, month, etc.)

Billing Information

Billing Address ____________________________ Phone # _______________________

City, State, Zip ____________________________ Email _________________________

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name ____________________________
Account/CC Number ____________________________
Expiration Date ____ /____ CVV ____ Zip Code _______

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify ______________ in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE ____________________________ DATE ______________________
(Cardholder's Signature)