COMPASS BEHAVIORAL

& DEVELOPMENTAL CONSULTANTS

Client Registration and Intake Packet

To Our Prospective Client,

Thank you for trusting Compass Behavioral & Developmental Consultants LLC. with your child's ABA & Speech Therapy. We are looking forward working with your child. Please complete the Client Registration and Intake packet to the best of your abilities so we can better understand your needs. Once we receive the completed packet and referral from your physician or diagnosing provider, we can schedule assessment and begin services. We are excited to assist you every step of the way. Please feel free to contact our clinics with any questions.

Within this packet you will find information regarding our policies and procedures. If at any time in this process you have any questions, please do not hesitate to contact us.

Once complete please email everything to either info@compassaid.com or:
Valdosta/Lakeland Clinic- officev@compassaid.com
Thomasville Clinic- officet@compassaid.com
Wearer Robins clinic- officew@compassaid.com

Sincerely,

Compass Clinical Team

Contact Information
Tel: (800) 832-9419 Fax (855-859-1671)
info@compassaid.com

Valdosta: 3121 N. Oak St Ext, Valdosta GA 31602 & 2935 N. Ashley St, Suite 120 Valdosta GA31602 Tel. (800) 832-9419 **officev@compassaid.com**	**Lakeland:** 32 W. Main St Lakeland, GA 31602 Tel. (800) 832-9419 **officel@compassaid.com**	**Thomasville:** 602 Victoria Pl. Suite A Thomasville, GA 31792 Tel. (800) 832-9419 **officet@compassaid.com**	**Warner Robins:** 225 Smithville Church Rd, Suite 1100 Warner Robins, GA 31088 Tel. (800) 832-9419 **officew@compassaid.com**

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Starting ABA Services:

1. Complete the Client Registration and Intake Packet including the following and email back to the office:
   - ☐ General Information
   - ☐ Copy of Insurance back and front
   - ☐ Physician Referral (to be sent from PCM)
   - ☐ Psychological Assessment
   - ☐ Client Registration
   - ☐ Release of Information
   - ☐ Authorization to Bill Insurance
   - ☐ Informed Consent
   - ☐ Financial Responsibility
   - ☐ HIPAA Service Agreement
   - ☐ Permission to Videotape and Photograph
   - ☐ Clinic Forms
   - ☐ Read through policies

2. We will obtain Pre-approval from the insurance company or signed Private Pay agreement prior to any evaluation, therapy, or any other services provided.

3. Initial Assessment – Once we receive the completed Intake Packet and pre-approval, we will set up an in-person appointment with a Board-Certified Behavior Analyst (BCBA) who will walk you through the assessment process and conduct individualized assessment. Several assessment tools may be used such as VB-MAPP, PEAK. PDDBI, AFFLES

4. BCBA will develop the Behavior Service Plan (BSP) – Based on the information gathered during the initial assessment, your BCBA will develop a comprehensive plan that may include: a summary of the assessment findings, target behaviors for reduction, replacement behaviors (skill acquisition goals), parent/caregiver goals, outline of teaching procedures and intervention strategies, and other recommendations for ongoing care. Please allow 1-2 weeks for BSP to be completed and sent to your insurance.

5. Parent Meeting – The BCBA will meet with you once the BSP is complete to review the plan, answer any questions, and make any desired changes.

6. Once insurance has approved the BSP, we will schedule a meet and greet with the BCBA and/or Registered Behavior Technician (RBT) who will be providing direct therapy.

7. On Going Service – Our office will confirm a consistent schedule of services which will include direct services with an RBT or BCBA, Parent Training and Plan Modification t record progress.

8. Monthly Caregiver Coordination Meeting – Each month the BCBA will meet with you to discuss progress and go over any changes or modifications that may be needed.

9. Re-Assessment – Every 6 months we will conduct a re-assessment and formally update the Behavior Service Plan.

Client Information

Full Name: ______________________________

Date of Birth: ______________________ Gender: ☐ Male ☐ Female

Address: ______________________________

City: ____________ State: ____________ Zip: __________

Insurance / Parent / Guardian Info

Other Insurance: Tricare
Medicaid
Both

Insurance Provider: ______________________________

Subscriber Name: ______________________ Date of Birth: __________

Subscriber Number / SSN: ______________________________

Group Number: ______________ Insurance Phone: ______________

Email: ______________________________

Occupation: ______________ Employer: ______________

Parent/Guardian: ______________________________

Relationship: ______________________ Date of Birth: __________

Address:
(if different form client) ______________________________

City: ______________ State: __________ Zip: __________

Cell Phone: ______________ Other Phone: ______________

Email: ______________________________

Occupation: ______________ Employer: ______________

Other Household Members

(Including Siblings Living with the Child)

Name:	Date of Birth/Age:	Relationship:

School Information

Name of School:	Attendance Time:	Therapies in School:

Emergency Contact Information

Contact 1: ______________________________

Relationship: ____________________ Phone: ____________________

Contact 2: ______________________________

Relationship: ____________________ Phone: ____________________

Other Service Providers

(relevant medical providers, Speech, OT, PT, etc.)

Primary Care Provider: ____________________ Phone: ____________________

Referring Provider: ____________________ Phone: ____________________

Name of Provider/Agency: ____________________ Phone: ____________________

Services Provided: ______________________________

Days/Times of Services: ______________________________

Name of Provider/Agency: ____________________ Phone: ____________________

Services Provided: ______________________________

Days/Times of Services: ______________________________

Name of Provider/Agency: ____________________ Phone: ____________________

Services Provided: ______________________________

Days/Times of Services: ______________________________

Client's Medical Information

Diagnostic Information:

Diagnosis	Diagnosis Date	Diagnosing Professional

Medical Conditions: ______________________________
____
____

Allergies: ______________________________
____
____

Is a rescue medication prescribed for any of the above listed conditions and/or allergies?

☐ No ☐ Yes (please list below)

Special Diet Information: ______________________________
____
____

Current Medication(s):
Please include all medications currently prescribed to the client and any medications stopped in the last 2 months.

Medication	Dosage	Frequency	Purpose

Hours of Availability

Please select the hours you are available for on-going direct services.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 AM					
9:00 AM					
10:00 AM					
11:00 AM					
12:00 PM					
1:00 PM					
2:00 PM					
3:00 PM					
4:00 PM					
5:00 – 6:00 PM					

Client's Strengths

What do you hope to achieve by receiving behavior services?

____

____

What is your familiarity with ABA services?

____

____

What skills does your child currently excel at?

____

____

____

What is an example of a new skill your child has learned recently?

____

____

____

Describe their favorite items and activities.

____

____

____

What strategies are you currently using that are helping/working?

____

____

____

What types of activities or settings are most likely to be successful for your child?

____

____

Any additional notes about your child's strengths:

____

____

____

Current Priorities

What are your top 3 priorities related to your child's skill development?

- ☐ Communication Skills
- ☐ Increasing Language
- ☐ Socialization with Peers
- ☐ Following Directions
- ☐ Independence in Daily Routines
- ☐ Independence Attending to an Activity
- ☐ Sharing/Turn Taking
- ☐ Other:___________________________

Describe what a typical day looks like for you.

____

____

____

Are there any current challenging behaviors? If so, please describe what they look like:

____

____

____

What is the hardest part of your day?

____

____

____

What activities would you like more support with?

____

____

____

Any other additional notes about your priorities?

____

____

____

Skills Overview

Does your child…

Use gestures (i.e., pointing) to communicate needs?	☐ Yes	☐ No	☐ Sometimes
Use sounds or partial words to communicate needs?	☐ Yes	☐ No	☐ Sometimes
Try to copy words they hear?	☐ Yes	☐ No	☐ Sometimes
Follow 1-step instructions (e.g., "give me," "sit down")	☐ Yes	☐ No	☐ Sometimes
Follow 2-step instructions (e.g., "get your cup & sit down)	☐ Yes	☐ No	☐ Sometimes
Spontaneously copy other's movements or actions?	☐ Yes	☐ No	☐ Sometimes
Help you during dressing?	☐ Yes	☐ No	☐ Sometimes
Help you during clean up?	☐ Yes	☐ No	☐ Sometimes
Calmly wait for a few minutes when an item/activity/person is not available?	☐ Yes	☐ No	☐ Sometimes

Remain calm during transitions? ☐ Yes ☐ No ☐ Sometimes

Remain calm when items are removed? ☐ Yes ☐ No ☐ Sometimes

Problem Behavior Information:

Behavior (Please describe what the behavior looks like)	How often? (# of times behavior occurs daily, weekly, or monthly)	How long? (how long the behavior occurs)	Severity (Please reference description below)

Mild – disruptive but little risk to self or others
Moderate – minor injury (redness, small bruising, small scratches), property destruction, and/or prolonged disruption
Severe – significant threat to health or safety, and/or property destruction resulting in significant damage.

What situations are the listed behaviors MOST likely to happen?
(Include people, places, activities, time of day, etc. that are relevant)

____
____
____

What have you already tried? Did it work/help?

____
____
____

What would you like your child to do instead?

____
____

This skill is…

☐ This skill is something they already know how to do.

☐ This is a new skill they would need to learn.

What is their current preference for communication:

☐ Vocal Language
☐ Visuals/Pictures
☐ AAC Device
☐ Sign Language/Gestures
☐ Pulling others toward them
☐ Other: ______________________

What types of rewards could be provided to motivate/reward your child?

Who is available to teach and reward this skill?

Describe how you like to teach new skills.

Describe your preferred method for handling challenging behaviors.

What are the top 3 expectations in your home?

Any additional notes/comments not yet addressed:

CONSENTS

Please initial by each section in the designated area, as well as provide your signature at the bottom of this page. Should you have questions please submit directly to: info@compassaid.com

General Consent to Treatment:

I consent to and authorize testing, treatment care by Compass Behavioral & Developmental Consultants LLC. I understand ABA uses evidence-based practices but is not an exact science and I acknowledge no guarantee has been made to me regarding the treatment I am to receive. Care this consent covers could include but is not limited to initial assessment for applied behavior analysis, ongoing direct ABA therapy sessions, parent / caregiver meetings / training, and / or any other procedures intended to be encompassed within this general consent. I understand if I am a recurring client, this consent applies until the completion of my treatment plan. I consent to the statements made in this form. Changes or alterations to this form are not binding on Compass Behavioral & Developmental Consultants LLC. Termination of services is always an option and may be made in writing by directly emailing info@compassaid.com

Signature: **Date:**

Consent to Telehealth:

I consent to part or all of my child's care being provided through telehealth services, which allows providers at different locations to examine sessions and make treatment modifications through electronic or other means of communication. I understand the risk of providers treating my child from remote locations and that, at any time, I can ask for clarification or further explanation of the type of care that will be provided via telehealth, as well as the benefits and risks of conducting therapy services through remote technology. Examples of telehealth services in ABA could be remote based assessments with your assigned BCBA/BCaBA/QASP-S; as well as supervision / plan modification done via web administration by your assigned BCBA/BCaBA/QASPS, while your RBT is providing in person direct services, Parent / Caregiver collaboration may also be hosted via web with your assigned BCBA/BCaBA/QASPS. Telehealth services are based on client specific needs and insurance eligibility.

Signature: **Date:**

Disclosure & Uses of Private Health Insurance

I acknowledge that my child's medical records may be kept or reviewed at locations within Compass Behavioral & Developmental Consultants LLC., other than the area where I am receiving care. I understand that medical or other information acquired in the past by any Compass Behavioral & Developmental Consultants LLC. provider and any information relating to the care provided at Compass Behavioral & Developmental Consultants LLC. facility may be used or disclosed, from time to time, to any other provider(s) for treatment, payment or healthcare operations purposes.

Signature: **Date:**

Information Sharing:

I give consent to my Compass Behavioral & Developmental Consultants LLC. to collaborate on my child's therapy services with parties employed or contracted within Compass Behavioral & Developmental Consultants LLC. I consent to Compass Staff collaborating with providers I have listed on my child's intake form including School / Daycare listed, Speech / Occupational Therapist, Primary Care Doctor, as well as other relevant providers. I understand collaboration of care would only be used on an as needed basis, in efforts of maximizing progress and success during my child's therapy. I understand I reserve the right to restrict collaboration at any given time and may do so by directly emailing info@compassaid.com alerting them of the date effective to no longer collaborate with listed providers. I understand in order for Compass Behavioral & Developmental Consultants LLC. to effectively collaborate on services for my child, I must update them on new or change of providers listed and may submit these changes to info@compassaid.com via email.

Signature: **Date:**

Insurance & Billing Consent

I consent to Compass Behavioral & Developmental Consultants LLC. verifying my child's eligibility and benefits through the insurance network provided on this intake packet, as well as any future insurance updates provided to Compass Office. I understand I must submit any insurance or coverage related changes to info@compassaid.com. I understand in order for Compass Behavioral to appropriately bill my insurance, I must maintain the responsibility of keeping my child's insurance plan current and informing Compass of any changes as soon as they occur, to ensure continued coverage is available. I understand Compass is in network with varying funding sources but not all. I understand that estimation of benefits is an estimate and is not a guarantee of insurance reimbursement and I am therefore responsible for any copayments, deductibles, out of pocket expenses.

Signature: **Date:**

I have read and understand the above consent agreements. By signing below, I acknowledge that I have provided or declined consent for the above items at my own will. Should I wish to change any of the above items, I will notify Compass office in writing.

Signature: ____ **Date:** ___________________

HIPAA Notice of Privacy Practices

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act requires us to notify you of our legal duties and privacy practices with respect to your protected health information and gives you, the patient, significant new rights to understand and control how your health information is used.

According to HIPAA, we may use and disclose your protected health information without your written authorization for the following reasons:

- Treatment including the provision, coordination, or management of healthcare and related services by one or more health care providers such as in the case of a referral to a specialist;
- Payment including activities such as filing an insurance claim in order to obtain reimbursement for services, confirming insurance coverage, obtaining pre-authorizations, and billing and collection procedures; and
- Healthcare operations including administrative, financial, legal, and quality improvement activities, such as a compliance audit, necessary to support and properly conduct treatment and payment activities.

We may contact you, by telephone or mail, to provide appointment reminders, test results, and/or treatment alternatives. You must notify us in advance if you do not wish for us to contact you for any reason.

Any other uses and disclosures, except as allowed or required by law, will be made only with your written authorization. You may revoke an authorization in writing, but such a revocation will not affect actions already taken by us based upon your prior authorization.

Examples of other uses and disclosures allowed or required by law which do not require a written authorization include:

- To notify family or other individuals involved in your care of emergency or critical care situations.
- For public health and safety purposes to prevent or control disease, injury, or disability threats.
- To report suspected victims of abuse, neglect, or domestic violence.
- For health oversight activities such as professional licensure and governmental program evaluation.
- For judicial and administrative proceedings pursuant to a court order or subpoena.
- For law enforcement purposes pursuant to due process.
- To assist coroners, medical examiners, and funeral directors in the performance of their duties.
- For organ donation purposes.
- For research purposes pursuant to a board approved waiver of authorization and research protection policies.
- For specialized governmental functions such as national security and intelligence activities.
- To comply with workers' compensation requirements pursuant to a signed release.

You have the following rights with respect to your protected health information.

- The right to request restrictions on certain uses and disclosures. However, we are not required to agree to such a request.
- The right to reasonable requests to receive confidential communications of health information from us by alternative means or at alternative locations.
- The right to inspect and/or receive a copy of your records for a reasonable fee.
- The right to request a correction or amendment to your records.
- The right to receive an accounting of disclosures of your health information.
- The right to obtain a paper copy of this notice from us upon request.

For assistance with exercising any of these rights, you may contact the Privacy Officer at the address listed below.

This notice is effective as of April 14, 2003, but we reserve the right to change the terms of this notice in accordance with new/revised laws or office procedures and make the new notice effective for all protected health information that we maintain. We will abide by the terms of the notice currently in effect, and you may receive a copy of the current notice at any time upon request.

If you feel your privacy rights have been violated, you may file a formal, written complaint with our Privacy Officer and/or with the Department of Health & Human Services, Office of Civil Rights at the addresses listed below. We respect your right to file such a complaint and will not retaliate against you for doing so.

Privacy Officer
Compass Behavioral & Developmental
Consultants LLC.
finance@compassaid.com
(800) 832-9419

U.S. Department of Health & Human Services
Office of Civil Rights
61 Forsyth Street SW, Suite 3B70
Atlanta, GA 30303-8909
(404) 562-7886

Compass Behavioral & Developmental Consultants LLC. provides information to inform our clients of the services our agency provides. The materials contained here are not intended to be used for the diagnosis or treatment of a health problem or as a substitute for consulting a licensed medical professional.
References to any non-governmental entity, product, service, or source of information that may be contained in this site should not be considered an endorsement, either direct or implied, by Compass Behavioral & Developmental Consultants LLC.

I acknowledge that I have received and reviewed the HIPAA Notices of Policy Practices.

Signature: ____ **Date:** ___________________

Compass Behavioral Policies

Cancellations

- Compass Behavioral & Developmental Consultants LLC. acknowledges that circumstances may arise where it may be necessary to cancel preexisting appointments and is empathetic to unforeseen circumstances that may result in missed sessions. In efforts to provide empathy, but also maintaining schedules for upcoming clients, we will ask that appointments be canceled minimum 24 hours in advance.
- Cancellations with less than 24 hours' notice, may result in a cancellation fee of $50.
- Late Pick up and late drop off may result in a fee of $50
- Excessive or persistent cancellations may result in redistribution of client's schedules, in efforts to manage potential schedule barriers.
- If these options are exhausted and inconsistencies continue, MBBS may pause therapy services until we are able to create a schedule that both parties are able to consistently commit to. With consistency being of the utmost importance in ABA therapy, we must work together in attempts to offer sustainable and effective therapy services.

Initial: _________

Cancelation Policies and Fees	Fee
No Call - No Show: Any session that does not start within 10 minutes of scheduled time and family has not contacted Compass BDC, LLC prior to scheduled time.	$50
Cancellation: Any session that is cancelled with less than 24 hours' notice.	$50
Late Drop-Off:_Family has informed Compass BDC, LLC that child will be present but more than 10 minutes after session start time. After 10 minutes, cancellation charge applies.	10+ mins: $50
Late Pick-Up: Family picks up child 10 or more minutes after scheduled session end time.	10+ mins: $50
If more than 2 occurrences of no call / no show arise, Compass reserves the right to pause services until we may create a schedule that both parties may commit too consistently.	**Initial:** ___________

Illness / Sick Policy

- If your child is ill for any reason, please notify the office so we may cancel your therapy appointment.
- Once your child is fever & symptom free for 24 hours, we may resume therapy services.
- This policy is in place in respect to both our providers, as well as other clients.
- Cancellations due to illness will be considered should cancellations become excessive. We will always do our best to work with everyone during these situations, which unfortunately, may best help to revamp the current schedule to better allow the client and family time to heal / adjust from

any medical related concerns. Once concerns subside and clients are able to be more present, we can plan to re-extend hours as soon as possible. This will allow families the opportunity to prioritize overall health & wellness while maintaining therapy services with our cancellation policy in mind.

Initial: _________

Diaper Changing / Restroom Assistance

- **In Clinic Services:** For client receiving in-clinic services providers will complete diaper changes during session and parents are obligated to send diapers and whips as well as change of clothes.
- **In Home/School/Daycare Services**: For clients receiving in-home, school or daycare therapy services, we will reserve diaper changes for the parent, teacher or guardian who is present during the therapy session.
- The exception to this policy would be for clients who are working on toilet training. For clients receiving toilet training assistance, it is the responsibility of the parent and / or guardian to provide diapers, pullups, wipes, change of clothes, etc. In order for this to be worked on, the "Restroom Consent" form must be filled out and returned to: info@compassaid.com

Initial: _________

Food & Snacks

- Compass Behavioral does not provide lunch or snacks to clients and asks that parents and / or guardians provide food and beverage items for the child.
- If the child participates in the social group program, snacks may be available, and it is important for the parent to fill out food sensitivity form and understands that child may be provided snakes on these special occasions.
- Many children do have food intolerances as well as boundaries. In efforts to respect and abide by this, we will ask parents and / or guardians to provide food and beverage related items to clients.
- Please fill and sign Food Authorization Form.

Initial: _________

Diaper/Bathroom Assistance Authorization Form

Child's Name:____DOB/Age:____________________

I authorize Compass staff to:
- ☐ Change diaper/pull-ups
- ☐ Apply ointment
- ☐ Assist with bathroom training/wiping
- ☐ Changing clothes

Apply ointment topically:
- ☐ When rash is present:
- ☐ With every diaper change
- ☐ Other:_________________________

Allergies to Latex: ☐Yes ☐No

Diaper/Pull-up Brand Provided:____

Ointment Brand Provided:____

Further Instructions:____

____
____
____

☐I **authorize** Compass BDC staff to change my child's diaper/take them to the bathroom, while in the clinic receiving treatment. I agree to supply an extra change of clothes, wipes, diapers, ointments, and any other supplies needed. I understand it is my responsibility to make Compass staff aware of any allergies or sensitivities related to diapers, ointments, or anything else of that nature. Compass will contact you if you we out of diapers. Staff will use gloves during the diaper change.

_______________________________________ ______________ ____________________________________
(Signature of Parent/Guardian) (Date) (Printed Name)

Food Authorization Form

Child's Name:____DOB/Age:____________________

List ALL known food allergies: ____
____
____
____

We are not a peanut, tree nut or allergen-free clinic. We do try to take precautions to ensure that your child does not ingest one of their known allergens. To best accommodate their needs, please provide a list of items they can and cannot eat.

Please list any food items they cannot ingest: ____
____
____
____
____

☐ I **authorize** Compass BDC to provide food/snack items.

☐ I **do NOT authorize** Compass BDC to provide food/snack items.

____
(Signature of Parent/Guardian) (Date) (Printed Name

Medication Administration

- Compass Behavioral does not administer medications for clients, unless this is a lifesaving medication to be used during crisis or emergent situations.
- If your child requires lifesaving medication, please ensure this is clearly defined in the medication section of this intake packet so we can better serve and protect your child should an emergent situation arise.
- **For Clinic Services** child will need to have action plan written by the physician outlining steps providers need to take, 911 will be called in case of emergencies.
- **For home services**, clients' parents or guardians who are present will be responsible for administering daily medication.
- **For daycare / school services**, the teacher / nurse / whoever is assigned at this facility to administer, will remain responsible for administering daily medications.

Initial: _________

Incident Reporting

- Compass Behavioral is dedicated to constructing a communicative relationship with the families of our clients. With safety at the forefront of our decision processes, we want to ensure families are actively aware of any incidents should one arise.
- While we hope this does not occur, in the event of an incident, Compass employees will complete an incident report form. We will share this incident report with the families on the same day, or within 24 hours at most from the time of the incident.

Initial: _________

Personal Information / Contact

- Compass does not permit the personal exchange of information between clients and providers, such as staff's personal phone numbers / emails. Clients can contact the office for any assistance and schedule changes.
- Should a client have any need to contact the RBT, BCBA, or office, please send all correspondence to info@compassaid.com or email appropriate clinic or call us directly at: (800) 9329419. We will work to return your call or email as soon as possible.

Initial: _________

Separated / Divorced Parents

- In our effort to service all types of families, we will refrain from participating in matters of child custody. We believe to most effectively service and benefit your child and family; it is in the best interest of all parties for us to remain neutral. Our focus is to provide effective therapy for the child.

  Compass will not keep separate records or communication logs for separated parents

- **Initial**: ______

Termination of Services

- Compass Behavioral reserves the right to cancel services at any time. Compass will always do our absolute best to give a minimum of 2-4 weeks' notice prior to canceling or referring out any client. Should your private insurance require additional time, our staff will oblige by this requirement and communicate this to the parent or guardian.
- We acknowledge that ASD is a large spectrum with individual needs. In the event we are unable to meet the needs of any client, we have an ethical obligation to refer them back to their PCM & Insurance and provide any resources available that may be a better fit for the client.

Initial: _________

Transportation

- Compass staff does not provide transportation to clients. If clients are in need of transport, the parent and/or guardian will be responsible for doing so.

Initial: _________

Clinic Services

- Drop of and pick-up for therapy services must be by assigned guardian, parents will need to notify our office in writing if **someone else is picking up or dropping off the child for services.**

Home Services

- During therapy services, an adult 18 or older must be present in the home, the entire duration of services.
- Compass does reserve the right to pause or discontinue services, should the home situation no longer be found conducive for therapy services.

Initial: _________

Financial Policy

Thank you for entrusting Compass Behavioral & Developmental Consultants LLC. as your ABA therapy provider. We are dedicated in providing best services for your child and our staff works hard to reach each child's potential. During planning for therapies it is important that parents are aware of financial policies and can plan accordingly.

Insurance

- Compass Behavioral is in network with a variety of insurance agencies / funding sources. If we are not participating in your specific insurance agency and/or funding source, the responsibility of payment will be the client's parent/guardian. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- **Copayments, Deductibles, Out of Pocket Expenses**
  All out of pocket expenses must be paid prior to services being rendered. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles / out of pocket expenses can be considered fraudulent. Copays will need to be paid on weekly bases by a recurrent payment and Credit card on file:
- **Non-covered Services**
  Please be aware that at times services may not be covered by your insurance plan. Should this arise, the parent/guardian will be responsible for all out of pocket expenses prior to the time of services being rendered.
- **Medicaid CMOS**
  If a client is switched to a different CMO and office was not notified, client is responsible for unpaid services. We ask clients to report any changes to the Insurance and CMO.
- **Proof of Insurance**
  All clients must complete our client intake packet in its entirety prior to beginning services. We must obtain a copy of your current and active insurance card to provide proof of insurance. If insurance information is not provided, you will be assumed as a self-pay client until verification of coverage is received.
- **Self-Pay**
  If you are not covered under an insurance plan, you will be considered a self-pay client. In order to be seen, payment for the scheduled sessions of one week's time, is due the week before services are rendered. This payment will be applied to your bill for services provided. Charges are based on the set fee schedule assigned by Compass Behavioral and agreed upon by the client's parent/guardian. Any additional services provided in the week that was not originally paid, such as reassessment, plan modification, parent / caregiver collaboration will be billed at the time of services. Clients will be required to have payment on file for ongoing services.
- **Claims Submission**
  Compass Behavioral will submit claims for services rendered to your insurance agency. We will work efficiently for services authorized to be reimbursed by your insurance agency. Your insurance agency may request additional documentation from you or your primary care. Patients are responsible for providing this additional information when required. Sometimes unforce circumstances, not providing requested information and overall insurance policies may result in claims being denied and therefore becoming full patient responsibility for payment of services rendered. Please be aware that the balance of any/all claims is your responsibility for services received.
  Your insurance benefit is a contract between you and your insurance company; we are not a part of that contract but will work diligently to assist in claim reimbursement.

- **Coverage Changes**
  Should you have a change in insurance, it is your responsibility to notify us before your next session so we can make the appropriate changes and assist in insurance reimbursement for all services provided. If your insurance company does not pay your claim within 45 days of the date of service, the balance will be automatically billed to you.
- **Nonpayment**
  Compass will send a monthly statement concerning any outstanding balances. It is your responsibility to pay any outstanding balances showing due by the date listed on your invoice. Recuring payments will also be charged 3 days after receiving invoices with the card on file.

  If your account is overdue, Compass Behavioral may pause therapy services until the balance is satisfied in full. Please be aware that should your balance remain unpaid past 60 days, your account will be turned over to a collection agency, where you will be responsible for any fees assessed to collect your past due amount(s) in addition to the outstanding bill.
- **Forms of Payment**
  Compass Behavioral accepts electronic credit / debit card payments from: Visa, Master Card, Discover, and AMEX. Compass also accept checks. We do not have ability to accept or cash payments.

  Compass will set up recuring payment for weekly co-pays however, payments can also be made by contacting us directly via phone call at: (800) 832-9419 b.

  Invoices will be sent to the email provided on your client intake packet or mailed to the address in your intake packet. If either of these addresses change, it is the parents' responsibility to update by contacting your local compass office.

By signing below, I acknowledge that I have received, reviewed, and understand the above policies of Compass Behavioral & Developmental Consultants LLC. I also understand that Compass reserves the right to change or add to these policies from time to time and I understand that I will receive notice prior to any modifications being made.

Signature: ____ **Date:** ___________________

HIPPA Notice of Privacy Practices

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

This Notice of Private Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of PHI

Your PHI may be used and disclosed by your physician our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a home health agency that provides care with you. For example, your PHI may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for therapy services that may require that your relevant PHI be disclosed to obtain approval for the approved therapy services.

Healthcare Operation: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training or medical students, licensing and conducting or arranging for the other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use sing-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: As required by law, Public Health Issues as required by law, Communicable Disease, Health oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement , Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity and National Security, Workers Compensation, Inmates, Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164,500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke the authorization at any time in writing, except to the extent that your physician or the Physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

You have the right to request a restriction of your PHI: This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to a family member or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices, your request must state the specific restriction requested and to whom you want the restriction to apply