Rose Street Mental Health Care – Spectrum
4084 S. Regent Dr.
Wichita Falls, TX 76308
Phone: (940) 228-5297 Fax: (940) 500-4025

Basic Identifying Information

Client Name:		Date of Birth:	Sex:
Home Adress:	City:	State:	Zip:
Current School:	Does your child have an IEP: Yes or No		
Classroom Setting (circle 1) General Education or Special Education	Number of hours enrolled in school per week: _____		

Parent Information

Mother's Name/Legal Guardian Name:	Date of Birth:	Social Security Number: _ _ _-_ _-_ _ _ _	
Home Adress:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Place of Employment:	Work Phone:		
Email:	Policy Holder: Yes or No		
Please Initial if you consent for RS Spectrum to leave a message: Home Phone #_____ Voicemail _____ Tex Cell #_____ Email_____			

Parent Information

Father's Name/Legal Guardian Name:	Date of Birth:	Social Security Number: _ _ _-_ _-_ _ _ _	
Home Adress:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Place of Employment:	Work Phone:		
Email:	Policy Holder: Yes or No		
Please Initial if you consent for RS Spectrum to leave a message: Home Phone #_____ Voicemail _____ Tex Cell #_____ Email_____			

Primary Insurance Information

Insurance Company:	Member ID:	Group Number:
Policy Holder Name:	Policy Holder DOB: _ _ / _ _ / _ _ _ _	Policy Holder SS#: _ _ _-_ _-_ _ _ _
Policy Holder Relationship to Client:	Tricare Specific: Reserve_____ Retired_____ Active_____	
Policy Holder/Parent/Guardian: **Insurance companies as well as Rose Street Mental Health Care require the insurance policy holder's Social Security Number to bill insurance and to bill the client. If an SSN is not provided, Rose Street Mental Health Care - Spectrum has the option to refuse services.*		

Secondary Insurance Information

Insurance Company:	Member ID:	Group Number:
Policy Holder Name:	Policy Holder DOB: _ _ / _ _ / _ _ _ _	Policy Holder SS#: _ _ _-_ _-_ _ _ _
Policy Holder Relationship to Client:	Tricare Specific: Reserve_____ Retired_____ Active_____	
Policy Holder/Parent/Guardian: **Insurance companies as well as Rose Street Mental Health Care require the insurance policy holder's Social Security Number to bill insurance and to bill the client. If an SSN is not provided, Rose Street Mental Health Care - Spectrum has the option to refuse services.*		

Please check one:

- ☐ The insurance policy holder is responsible for the bill. Their address has been listed in the Basic Identifying Information section. They are aware of their responsibility and that they are listed in this document.
- ☐ The insurance policy holder is not responsible for the bill.

Listed is the parent/guardian responsible for the bill: _____

Primary Household Information

Client's Parents/Legal Guardians Are: Married_____ Separated_____ Divorced_____ Other_____			
Please list other individuals that reside in the child's primary household or other relevant/immediate family members not listed in Basic Identifying Information and the Insurance Information section. **Contact information is only required for additional caretakers/guardians.*			
Name	**Age**	**Relationship**	**Phone Number**

Secondary Household Information

Please list other individuals that reside in the child's primary household or other relevant/immediate family members not listed in Basic Identifying Information and the Insurance Information section. **Contact information is only required for additional caretakers/guardians.*			
Name	**Age**	**Relationship**	**Phone Number**

Approved Caretaker Information

Please list other individuals that reside in the child's primary household or other relevant/immediate family members not listed in Basic Identifying Information and the Insurance Information section. **Contact information is only required for additional caretakers/guardians.*			
Name	**Age**	**Relationship**	**Phone Number**

Treatment History

Current Pediatrician:	Phone Number:	Fax Number:
Psychologist/Diagnostician:	Phone Number:	Fax Number
My child currently has a diagnosis of Autism: Yes _____No_____	Severity level of Autism Diagnosis (Please refer to Psychological Evaluation): __ Level 1- Mild __ Level 2- Moderate __ Level 3- Severe	
Date of Last Assessment: _ _/_ _/ _ _ _ _	Date of Diagnosis: _ _/_ _/ _ _ _ _	
Has your child ever been assessed for co-morbid disorders? Yes or No If unsure or If yes, please list any additional diagnosis:_____ _____		
Please List below all allergies (food, medication, seasonal): _____ _____ _____ _____		
Referred to Spectrum By:		

Medications

This is required to report to insurance

Medication	Dosage	Prescribing Physician

Other Therapy Services Received

Speech Therapy, Occupational Therapy, Physical Therapy, Psychotherapy/Counseling

Service Type	Intensity/Week	Response to Treatment	City & State of Service

ABA Current and Past Treatment History

Please include all prior ABA services, as well as start date of current services

Services Dates	Intensity/Week	Provider	Response to Treatment

ABA Therapy Availability

Please list the days and times your child will be available to attend therapy. Rose Street Mental Health Care - Spectrum utilizes a block scheduling system according to recommended treatment hours. (ex. Mornings, Afternoons, After School, or Full Day)

Day	Beginning Time	End Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Family History

Please list genetically related family members that have had a history of medical or psychological disorders.

Relationship to Child	Diagnosis

Current Concerns

Please tell us what prompted you to seek ABA services. Do you have specific concerns related to your family/home life?

_____
_____
_____
_____
_____
_____
_____

Please check any of the following concerns that may have prompted you to seek ABA services:

___Social Skills Deficits
___Communication Delays
___Repetitive/Stereotyped Behaviors
___Echolalia
___Pica
___Hyperactive
___Impulsive
___Inattention
___Aggression (towards others or property)
___Self-Injurious Behavior
___Verbal Aggression
___Self-Regulation Problems
___Toileting Concerns
___Refusal/Defiance
___Feeding/Restrictive Eating Concerns
___Functional/Daily Living Skills Concerns
___Elopement/Runs away
___Play Skills Deficits
___Mood Disorders
___Inappropriate Sexual Behaviors
___Other: _____
___Other: _____

Additional Information

Please answer the following information to the best of your ability. This information will be used for your child's assessment and utilized especially at the start of their services.

Please list what your child enjoys in the following categories:

Food: _____

Toys: _____

Games: _____

iPad use: _____

Music: _____

Charaters: _____

Please list any fears or anything we should avoid that causes a high emotional reaction or can trigger behaviors:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Your Information, Your Rights, Our Responsibilities

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.

Your Rights

When it comes to the client's health information, parents/guardians have certain rights. This section explains parents/guardian's rights and some of our responsibilities to help.

- Parents/guardians may request to see or receive an electronic or paper copy of the client's medical records and other health information we have about the client. Ask us how to do this. We will provide a copy or a summary of the client's health information, usually within 30 days of your request. We will copy 10 pages for free. Any page after that will be $0.10/page. Emailing records will be free of charge.
- Parents/guardians may request that we correct health information about the client that the parents/guardians think is incorrect or incomplete. Ask us how to do this. We may say no to the request, but we will tell you why in writing within 60 days.
- Parents/guardians can request that we contact the parents/guardians in a specific way (for example, home or office phone) or that we send mail to a different address. We will agree to all reasonable requests.
- Parents/guardians may request that we *not* use or share certain health information for treatment, payment, or our operations. We are not required to agree to the request, and we may decline the request if we determine that it would affect the client's care.
- If the parents/guardians pay for a service or health care item out of pocket in full, the parents/guardians may request that we not share information for either purpose of payment or our operations with the parents/guardian's health insurer. We will agree to the request unless a law requires us to share that information.
- Parents/guardians may request a list (accounting) of the times we have shared the client's health information, with whom we shared it, and why for a period of 6 years from the date of the request. We will include all relevant disclosures except for those about treatment, payment, health care operations, and certain other disclosures. We will provide one accounting per year at no charge, but will charge a reasonable, cost-based fee if another request is made within 12 months.
- Parents/guardians may request a paper copy of this notice at any time, even if the parent/guardian has agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- If the parents/guardians have given someone medical power of attorney, or if someone is the client's legal guardian, that person may exercise parents/guardian's rights and make choices about the client's health information. We will ensure that the person legally has this authority and can act for the client before we take any action.

Complaints

- If you feel we have violated your rights, you may complain by contacting any clinical director at (940)228-5297.
- You may file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- You may complain to the Behavior Analysts Certification Board by visiting https://www.bacb.com/
- We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Please sign and date below stating you have received, read, and understand the notice of your information, rights, and our responsibilities.

Signature: _____ Date: _____

(Information, Rights, and Our Responsibility)

Informed Consent for Behavioral Services

Before intervention can begin, the parent/legal guardian agreement to the business practices described herein is required. It is important that you read through this information carefully and ask questions for clarification at any time. When you sign this document, it will represent an agreement between you and Rose Street Mental Health Care - Spectrum to provide ABA services.

This document describes the nature of the agreement for professional services, the agreed upon limits of those services, and the rights and protections afforded under the Behavior Analyst Certification Board's Guidelines for Responsible Conduct of Behavior Analysts. The parent/legal guardian will receive a copy of this document to retain for your records. All fees for services and payment arrangements will be reviewed separately.

I, _____ [PARENT/LEGAL GUARDIAN NAME], agree to have my child/dependent, _____[CHILD/DEPENDENT NAME], participate in Applied Behavior Analysis (ABA) treatment services provided by employees of Rose Street Mental Health Care- Spectrum. I understand that the specific activities, goals, and desired outcomes of these ABA services will be fully discussed with me. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation in services.

X_____(initial) If these services have been arranged or will be paid for by a third party (i.e., school, insurance plan, state agency), I am aware that the third party has the following rights: to determine services, to review documentation of sessions for billing purposes, to view the results of assessments, and to receive written reports.

Signature: _____ Date: _____

(Informed Consent for Behavioral Services)

Treatment Determination

ABA therapy is an evidence-based best practice for individuals with autism. Most insurance companies require an autism diagnosis to fund ABA services. Rose Street Mental Health Care-Spectrum will provide ABA intervention if upon assessment our BCBA feels that deficits and excesses can best be addressed using this treatment model and there are not prohibitive barriers to effective treatment. The BCBA will also recommend the number of hours that they deem medically necessary to make socially significant gains. Examples of when ABA therapy may not be medically necessary may be with a child with additional diagnoses where ABA therapy has not shown to be effective or if the family is unable to engage in sessions consistently, thereby affecting treatment effectiveness. Our goal is to fade-out services and have your child thrive independently without our assistance. Eligibility for titration (ending) of services includes challenging behaviors occurring at levels that no longer impede everyday functioning or are appropriately managed by your child acquiring the functional skills required to access their natural environment in a meaningful way.

By signing below, I am confirming these policies have been fully explained to me, and I fully and freely give my consent and permission for my dependent.

Signature: _____ Date: _____
(Treatment Determination)

Billing, Payment Policy, & Financial Responsibility

Please read the following, initial and sign below to indicate you have read and agree to the following policies:

X_____ Parents/guardians are personally responsible for knowing and understanding their insurance policy, eligibility, and coverage.

X_____ I understand that if I would like a copy of the Explanation of Benefits for insurance claims filed, it is my responsibility to look up the Explanation of Benefits with my insurance company. Rose Street Mental Health Care - Spectrum is not responsible for providing this information. Each insurance company has a portal to provide this information.

X_____ Authorization for treatment from your insurance company does not guarantee full payment for the services. Not all insurance companies/third party payers pay for all services; each policy has its stipulations regarding covered services or amount of coverage.

X_____ All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Your insurance company determines actual benefits after a claim is received.

X_____ I understand that if my insurance does not pay for services provided, I will be responsible for the charges. I understand that this will not be included in my financial responsibilities stated in my insurance benefits.

X_____ All patient financial responsibility must be paid specifically to your child's insurance/child's account to avoid any interruptions in service. Patients are responsible for payment of outstanding deductibles and co-insurance amounts at the time of service. Co-payments will be collected at the time of service.

X_____ I understand that failure to pay amounts due could result in discontinuation of therapeutic services.

X_____ I have been informed that bill payments can be made in the form of cash, personal check, cashier's check, or credit card. Additionally, I understand that returned checks are subject to a $25.00 fee.

Billing, Payment Policy, & Financial Responsibility (Continued)

Please read the following, initial and sign below to indicate you have read and agree to the following policies:

X_____ Patients are financially responsible for payments of all non-authorized procedures and non-covered services. Changes in insurance coverage must be reported to our staff before changes are made. If insurance changes are made without staff being notified, the family will be held responsible for the full price of services rendered that are not covered during the lapse in insurance coverage.

X_____ An annual financial contract will be written by a representative of Rose Street Mental Health Care - Spectrum based upon the family insurance benefits. I understand that Rose Street Mental Health Care – Spectrum is not responsible for determining what my insurance benefits are. Any other fees will be disclosed at the time of the meeting and are discussed in detail further in the application paperwork. Rose Street Mental Health Care - Spectrum is not responsible for insurance benefits and deciding what the billing rates will be. Billing rates is the insurance company's determination. If a financial contract is not written or agreed to, the family will pay each bill in full every month or pay at the time services are rendered.

X_____ I authorize Rose Street Mental Health Care - Spectrum to bill said insurance directly and disclose any documents required by the insurance company for continued services. I understand that a refusal to sign will leave filing insurance up to the family's responsibility, it will leave all unpaid services as the family's financial responsibility, and if there is a failure of the family to submit insurance claims in a timely manner, Rose Street Mental Health Care – Spectrum has the right to terminate services.

My signature below signifies that I have read and understand this client financial agreement for Rose Street Mental Health Care - Spectrum for ABA therapy services. I agree to the terms in this agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, my child could be discharged from services.

Signature: _____ Date: _____

(Billing, Payment Policy, &Financial Responsibility)

Emergency Assistance

Please initial by only 1 of the following and sign below.

X_____ I give Rose Street Mental Health Care - Spectrum permission to administer First Aid/CPR on my child if an emergency arises.

X_____ I do ***NOT*** give Rose Street Mental Health Care – Spectrum permission to administer First Aid/CPR on my child if an emergency arises. By checking this box and signing below, I understand I am signing a Do Not
Resuscitate order and Rose Street Mental Health Care – Spectrum will not be held liable for health consequences due to not being able to perform First Aid/CPR.

Signature: _____ Date: _____
(Emergency Assistance)

Behavioral Crisis Emergency Assistance

Rose Street Mental Health Care – Spectrum utilizes Safety-Care® Behavioral Safety Training for client crisis intervention. The Safety-Care® Behavioral Safety Training program provides the skills and competencies necessary to effectively prevent, minimize, and manage behavioral challenges with dignity, safety, and the possibility of change. Safety-Care® provides the tools needed to be safe when working with behaviorally challenging individuals. Using up-to-date and effective technologies from Applied Behavior Analysis (ABA) and Positive Behavior Interventions & Supports (PBIS), the Safety-Care® program provides our staff with strategies for preventing and managing behavioral challenges and teaching replacement behaviors. These strategies are appropriate for individuals experiencing developmental, neurological, psychiatric, and other impairments. SafetyCare® promotes a positive reinforcement-based approach, and the development of new skills, resulting in fewer restraints.

Rose Street Mental Health Care – Spectrum will provide a Written Summary of Restraint Use form to the parent/legal guardian the day that Safety-Care® Behavioral Safety Training has been utilized with my child. This form will explain the client's engagement which led to restraint, efforts the staff made to de-escalate the situation, the alternatives to restraint that were attempted, a physical observation of the client at the end of restraint and will name the staff members that participated in the restraint.

Behavioral Crisis Emergency Assistance (Continued)

By signing, I have read and understand the use of Safety-Care® Behavioral Safety Training and hereby acknowledge that Rose Street Mental Health Care - Spectrum utilizes Safety-Care® Behavioral Safety if a behavioral emergency arises that would place my child or other person at risk for injury. I understand that if I have questions at any point regarding Safety-Care® Behavioral Safety Training, I may speak to my child's BCBA.

Signature: _____ Date: _____
(Behavioral Crisis Emergency Assistance)

Required Parent or Legal Guardian Involvement

This is a requirement of your insurance carrier.

Parents/legal guardians are encouraged to be active participants in their child's therapy sessions by scheduling time to observe through the BCBA. In fact, many insurance companies require parent/legal guardian participation to be included in the treatment plan for authorization of ABA services. After scheduling an appointment, participation can be achieved in multiple ways: observation, shadowing and active participation are just a few of the ways we allow for parents/legal guardians to engage during ABA therapy. You are welcome to observe your child's entire session or observe only a part of the session, so long as it is not disruptive to the therapeutic process for your child and other children receiving services. A waiting room is available when you are no longer observing your child, or you may leave and return to pick your child up when their session is finished. Please make arrangements for your other children when you are observing; it is possible that their presence will distract others and become disruptive to therapy sessions. Children of any age cannot be left unattended. Cell phones need to be silenced while observing to avoid disruptions during therapy. We also ask that parents/legal guardians take notes of their questions or comments and address these with the BCBA/BCaBA through email or an appointment to meet instead of discussing with the RBT during the session.

Policy on Unattended Children

Rose Street Mental Health Care - Spectrum requires that a caregiver over the age of 18 be present always while an RBT, BCaBA or BCBA is engaged in an in-home or community-based session. If a parent/legal guardian or caregiver brings their child/children to the clinic and leaves before their therapist is available to take them, a meeting will be held between the BCBA and a parent/legal guardian for this to be addressed. Children cannot be left unattended in the lobby or outside. Office staff is not responsible for monitoring unattended children.

Signature: _____ Date: _____
(Unattended Children Policy)

Community-Based Intervention

Please initial each paragraph and sign below.

X_____ Your child may have the opportunity to participate in community-based intervention. During these times the parent/legal guardian will be required to transport your child to and from the activity. Additionally, parent/legal guardian attendance might be necessary on a case-by-case basis.

X_____ I agree for Rose Street Mental Health Care – Spectrum to engage in community-based intervention. By agreeing to this waiver, I do not hold Rose Street Mental Health Care - Spectrum responsible for any injury, damage of property, or other unforeseen incidents that occur during the community-based intervention.

X_____ I acknowledge that community-based intervention limits confidentiality due to its public location.

Signature: _____ Date: _____

(Community-Based Intervention)

Personal Hygiene

When deemed medically necessary as part of a treatment plan or with parent permission, Rose Street Mental Health Care – Spectrum works on personal hygiene skills. All skills that staff will work on with the child will be discussed between parents and the child's BCBA before attempts are made. Please read the following, initial and sign below.

X_____ I understand that I am required to ensure my child's hygiene is kept up with daily. My child's hygiene is not Spectrum's responsibility. The only time personal hygiene steps should be skipped prior to a therapy session is if my child's case manager has specifically asked me to refrain from doing so for a therapist to work on these skills in the clinic.
I understand that if my child is brought to the clinic with hygiene issues, Spectrum has the right to send the child home. If this becomes a consistent issue, the child's BCBA can hold a meeting with the parents/legal guardians.

X_____ I consent to have Rose Street Mental Health Care – Spectrum use shampoo, deodorant, toothpaste, conditioner, nail clippers, Q-tips, hairbrush, and hair ties to maintain a healthy hygiene for my child while in the clinic if deemed necessary by their BCBA.

X_____ I understand that hair clippers will only be used on my child after a parent request is made or the BCBA holds a meeting to discuss in further detail.

Signature: _____ Date: _____

(Personal Hygiene)

In-Home Services Guidelines

To provide your child with the most effective therapeutic services, we ask that you observe the following guidelines for in-home sessions. Your cooperation in these matters is greatly appreciated to assist us in working with your child.

- Your child should be awake, dressed, and fed prior to therapist arrival, unless these skills are being specifically addressed in their goals.
- A parent/legal guardian or other responsible adult (over the age of 18) must be present and accessible for the entire session.
- The area being used for therapy should be well-lit, a comfortable temperature, and relatively free of distractions. It is important that we can conduct the session in a professional, therapeutic manner with limited access to competing reinforcers, such as a television or toys that will not be used for therapy.
- Please do not use therapy materials and reinforcers outside of therapy time. If you would like to run a program with your child, please let your child's supervisor know and we will gladly train you on how to run the program and take data.
- Although we encourage you to observe the session whenever you like, please do not interfere or interrupt without first discussing it with the supervisor. If you have questions or concerns about an intervention, please address them with the supervisor afterwards. Do not interrupt the session.
- All functional supplies should be readily available to staff for the duration of the appointment. For example: diapers, wipes, shoes for outside, toys for reinforcement and food for mealtime.
- Safety- If our clinical staff enter your home to provide therapy to your child, we need to ensure the safety of the staff and your child. If we feel that your home is not sanitary, is hostile or in any way poses a danger to their well-being, we reserve the right to request therapy occur at another location.

Signature: _____ Date: _____

(In-Home Service Guidelines)

Prescription and Over the Counter Medication

Rose Street Mental Health Care - Spectrum does not administer prescription medications without a doctor's orders. Please give the doctor's orders to the front office, along with the medication in the original, labeled medication bottle with the name of the child on it. A parent/legal guardian will be required to fill out a medical release form as well. The front office will provide the necessary form.
Over the counter medicine needs written consent from the parent/legal guardian that includes dosage, times to administer medicine and for length of time (days, months, years). We require the medicine to be provided with original packaging.

Non-Prescription Medications and Ointments

Please read the following, initial and sign below.

X_____ I agree to allow Rose Street Mental Health Care – Spectrum to put non-prescribed ointments, sprays, and creams on my child when deemed necessary. This includes but is not limited to products such as sunscreen, bug spray, Neosporin, lotion, and rash cream. If my child has any allergies to these products, it has been listed in the Medical and Diagnosis History section of application and I will provide Spectrum with the supplies.

X_____ Rose Street Mental Health Care – Spectrum will not administer these non-prescribed medications without a phone call to parents for consent.

- Pain reliever
- Non-prescription allergy medication
- Eye drops

Signature: _____ Date: _____
(Prescription and Non-Prescriptions)

Cancellation Policy

If your child is going to be absent, a 24-hour notice is required with the exception of illness. In the case of illness, we ask that families give us a 1-hour notice when possible.

Outside of the exception of illness, a cancellation with less than a 24-hour notice will accrue a $25 no-show fee. One warning a year will be sent before implementing a $25 no-show fee.

Signature: _____ Date: _____
(Cancellation Policy)

Late Policy

There will be a 5-minute grace period for drop offs and pickups in which no fee is accrued with no penalty. If we feel this is becoming problematic, it will be re-addressed.

At the 6-minute mark, a $5 fee will be applied. This fee covers minutes 6-15.

- 3 grace periods will be allowed in a 3-month period.
- When a parent is between 6-15 minutes late for the 3rd time in a 3-month period, notice will be sent to the parent/legal guardian that their grace period has expired, and they will be charged for the next late drop off or pick up.

At the 16-minute mark, a $1/minute fee will be applied after the $5 fee has been applied for minutes 6-15.

- 1 grace period will be allowed in a 3-month period. Notice will be sent to the parent/legal guardian that their grace period was used.

Please know we will have more consideration for late arrivals than late pickups and will take each individual's circumstance into consideration. If behavior is part of the issue this would be a great time to address this with your child's BCBA. Please note that this policy applies to all caretakers and the family will be held responsible for any fees caused by caretakers. The family will not be penalized for late drop offs by the school bus system or the ARC.

As with everything we do, data will be collected and analyzed. We will review data and make changes as necessary. If changes are made, all families will be emailed before new policies become active. If policies change, a new application paperwork will be mandatory for families to re-fill out within one calendar year. We welcome your feedback and are open to meeting with anyone with concerns, comments, or questions.

Signature: _____ Date: _____
(Late Policy)

Communication Policy

When notifying staff of early/late drop offs, early/late pickups, and cancellations, the family must contact the front desk during business hours of 8am-6pm at (940)228-5297. Outside of the business operating hours, families can email wfspectrum@gmail.com

Additionally, our staff will communicate with families through the business office or email. Either the office staff will call on behalf of the BCBA or the BCBA will call if necessary. Topics such as food, diapers, changes of clothes, client illness during session, etc. will be addressed through a phone call from the business office or through email from the BCBA, depending on the timeliness required.

The purpose of this is to create a regulated system of communication between staff and families in hopes of reducing potential opportunity for miscommunications.

Disclaimer

Regarding these policies, if an explanation for a cancellation or lateness is not given, it will be assumed that the reason for these events in not within the exceptions we make.

By signing, you are acknowledging that you have read and understand the expectations for your child to continue receiving services from Rose Street Mental Health Care - Spectrum.

Signature: _____ Date: _____
(Communication Policy & Disclaimer)

General Health Requirements for Daily Sessions

As a therapy clinic, it is imperative that children not come in clinic while sick. Please read the following, initial and sign below.

X_____ I understand that if my child has any of the following symptoms, they should not be brought into the clinic:

- Vomiting
- Diarrhea
- Pink Eye
- Head lice
- Fever of 99.4 or higher
- Symptoms of any communicable disease (Note: Please notify the front desk of any infections disease your child has such as chicken pox, measles, mumps, COVID-19, influenza, etc.)

X_____ I understand that if my child presents with any of the above symptoms, they will be sent home.

X_____ I understand the policy that if my child presents with any of the symptoms above, they must be symptom-free for 24 hours before returning to the clinic.

X_____ I understand that if parents/legal guardians cannot be reached, alternate names from the Emergency Contact form will be called to pick up my child.

X_____ I understand I am required to disclose if my household has lice, fleas, or bedbugs. Due to how quickly these parasitic insects can spread, we ask that services be placed on hold until this situation is resolved.

Please read and initial below for our non-illness related policies for sending children home.

X_____ I have read and understand the following disclaimer: As a therapy clinic, it is unethical and illegal for us to bill insurance if a child is unable to perform therapeutic tasks. This means that if a child has not had sufficient sleep, has too severe allergies, is emotionally inconsolable after multiple attempts, has vomiting or diarrhea without other illness symptoms presented, has migraines, is under heavy medication, etc., it is deemed "not therapeutic". When a child's state is deemed "not therapeutic", they will be sent home. It is up to the discretion of the child's BCBA or a clinical director to make the determination to send the child home.

X_____ I understand it is my responsibility to ask ahead of time if my child's health is questionable, and it will be up to the determination of a BCBA on whether my child will come in for their session that day. If the BCBA determines my child cannot come in for the day and sufficient notice was given in accordance with the attendance policy, there will be no penalty.

Signature: _____ Date: _____

(General Health Requirements)

Fee Notification Preference

Please initial one of the options below to indicate communication preference for warnings and fees.

X_____I prefer notices to be sent through e-mail. If so, please check only one of the following:

- ☐ The person responsible for the bill is the insurance policy holder and their name and email address has been listed above in the Basic Identifying Information section (pg.1).
- ☐ The person responsible for the bill is not the insurance policy holder. The person responsible for the bill is aware of their responsibility, is aware of Rose Street Mental Health Care- Spectrum's policies and is aware their email is being listed. The name and email address of the person responsible for the bill is listed below:

X_____I prefer notices be sent through mail. If so, please check only one of the following:

- ☐ The person responsible for the bill is the insurance policy holder and their name and address has been listed above in the Basic Identifying Information section (pg.1).
- ☐ The person responsible for the bill is not the insurance policy holder. The person responsible for the bill is aware of their responsibility, is aware of Rose Street Mental Health Care- Spectrum's policies and is aware their name and address are being listed. The name and address of the person responsible for the bill is listed here: _____

Photo/Video Consent and Release

The Rose Street Mental Health Care - Spectrum utilizes a variety of different digital devices to monitor your child's progress (video, audio, and photograph). The products of these devices maintain confidential standards and are not released without the explicit permission of the parent/guardian.

By signing the consent form below, I am granting Rose Street Mental Health Care - Spectrum exclusive rights and use of these products for training, and research. Please read the following, initial and sign below.

X_____ I hereby authorize and give my consent for Rose Street Mental Health Care - Spectrum to use their collection of digital products (video, audio, and photograph) of my child for training and research.

X_____ I understand that even after withdrawing photo/video consent for training and research purposes, Rose Street Mental Health Care – Spectrum will always maintain video surveillance of the clinic. These videos are for safety purposes and will not be released for any purposes unless it is to law enforcement because a crime has been committed or court ordered documents have been provided by law enforcement.

X_____ I understand I can withdraw my photo and video consent for training and research purposes at any time.

Signature: _____ Date: _____

(Photo/Video Consent & Fee Notice Preferences)

Edible Reinforcement Utilization

Rose Street Mental Health Care – Spectrum will provide clients with edible reinforcement. Please read the following, initial and sign below.

X_____ I understand it is my responsibility to inform Rose Street Mental Health Care – Spectrum of any allergies my child may have, or food and drink intolerances. Failure of this notification will leave parents liable for the consequences.

X_____ I understand that the supply fee that we use to provide reinforcements for my child cannot be billed through insurance.

Signature: _____ Date: _____
(Edible Reinforcement Utilization)

Personal Supply Requirements

Rose Street Mental Health Care – Spectrum is not responsible for providing meals, diapers, feminine products or clothes to clients. Parents/Legal guardians are required to provide any of these items for the time the client is in therapy.

When personal care items are low, the front office will contact parents/legal guardians requesting more personal supplies be provided. There will be a 24-hour window for those supplies to be provided. Rose Street Mental Health Care – Spectrum has the right to send a client home if adequate personal supplies are not provided.

If there is inability to provide the supplies in the timeframe allotted, Spectrum will provide the parents/legal guardians with a receipt for the purchase made on behalf of the client. The parent/legal guardian will have two weeks to reimburse Spectrum for the supplies. Please communicate with us if this becomes an issue and alternative arrangements need to be made. These fees are separate from all other fees and cannot be billed to insurance.

If this becomes a consistent issue, the child's case manager or a clinical director will request a parent/legal guardian meeting.

By signing, you are acknowledging that you have read and understand the expectations for your child to continue receiving services from Rose Street Mental Health Care – Spectrum.

Signature: _____ Date: _____
(Personal Supply Requirements)

Supplies, Reinforcement, and Snacks

Parents will be responsible for completing a survey for their treatment team that will identify a variety of reinforcement and snacks that can be purchased to help motivate and reinforce your child throughout the session to accomplish their targeted goal using their reinforcement.

Supply Fees for Reinforcement

Client hours < 15 Hours of Services = $20/month

Client hours > 15 Hours of Services = $33/month

By collecting the supply fees allow us to have ready access to your child's specific reinforcement needs and provides us the liberty to therapeutically change the reinforcement procedures when necessary. We greatly appreciate your participation in our efforts to provide your child with the best therapeutic opportunity to gain optimum growth using reinforcement.

I AGREE THAT ROSE STREET SPECTRUM CAN COLLECT THE ABOVE STATED SUPPLY FEES. By agreeing to this waiver, I UNDERSTAND THAT THESE FEES WILL BE ADDED TO MY Rose Street Spectrum account, and I AGREE TO PAY for the fees monthly.

Signature: _____ Date: _____
(Reinforcement, Supplies, Snacks & Supply Fees)

Participant Agreement, Release, and Liability Waiver
Reinforcement Equipment

For therapy to be most effective, Rose Street Mental Health Care – Spectrum utilizes various equipment for reinforcing purposes and the growth of necessary skills. Items may include but are not limited to the following:

- Play swings
- Trampoline
- Bicycles
- Indoor play equipment
- Outdoor play equipment

Signature: _____ Date: _____
(Participant Agreement, Release, & Liability)

Hygiene and Living Skills Equipment Consent

Due to the nature of ABA Therapy, many of our goals align with independent living skills or improved, dependent living skills. I give consent for my child to use equipment necessary to perform the following skills or tasks:

- Cooking and baking
- Sweeping
- Mopping
- Washing dishes
- Use of chemical cleaning agents

Please read the following, initial and sign below.

X_____ I have read and understand that Rose Street Mental Health Care – Spectrum will not have children clean as a replacement for hiring a cleaning company.

X_____ By signing this document, I acknowledge on behalf of myself, and the minor child(ren) listed in this agreement that if any participant is hurt or property is damaged during the child(ren)'s participation in these activities, the family has waived the right to maintain a lawsuit against Rose Street Mental Health Care – Spectrum.

X_____ I further acknowledge that I have had sufficient opportunity to read this entire document. I understand this agreement and I, on behalf of myself and the participants listed in the agreement, am voluntarily agreeing to be bound by its terms.

X_____ I further certify that I am the parent or legal guardian of the child listed above on this agreement, or that I have been granted power of attorney to sign this agreement on behalf of the parent or legal guardian of the child listed in this document. If I do not have the requisite authority to sign this agreement on behalf of the child listed above, I agree that I shall be solely liable for any and all actions, causes of actions, penalties, claims, costs, services, compensation or the like resulting from this misrepresentation. I agree to be contractually bound by this certification.

Signature: _____ Date: _____

(Hygiene and Living Skills Equipment)