simply stars

INTAKE PACKET

PROUD MEMBER OF

THE PERFECT CHILD TPC

615-981-6023 SimplyStars@tpcaba.com SimplyStarsABA.com

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Dear Parents/Guardians,

Welcome to Simply Stars! We are grateful that you are interested in our program and look forward to meeting you and your family. Simply Stars is a school-based and home-based ABA (Applied Behavior Analysis) program that provides one-on-one therapy for children diagnosed with Autism, as well as other Autism Spectrum Disorders. Simply Stars looks to provide a quality and caring service to each child that is enrolled. Each staff member is highly trained and dedicated to meet the needs of the families and children they serve.

The first step in enrolling in our program is completing the necessary paperwork for your child. Please thoroughly fill out each page of the client application packet that is provided below. Once you have completed the forms you may submit it by mail, drop it off or fax it to the agency. In addition to the application packet, attach all medical documentation relating to the autism diagnosis (this must include Neuropsychological Evaluation) and a copy of your child's insurance card. We will be in contact with you when I receive the application packet to continue the intake process. If you have any questions along the way, please contact us.

Thanks again for your interest in our program!

INTAKE PACKET

Today's Date:

Client Legal Name: _____

Last Name First Name Middle Initial

Name Client goes by: _____ Date of Birth: _____ Gender: ____

Home Address: _____

City: _____ State: _____ Zip: _____

Name of School: _____

FAMILY INFORMATION

Client lives with: _____

Parent/Guardian 1

Name: _____ Relationship: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Employed by: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

Parent/Guardian 2

Name: _____ Relationship: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Employed by: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

EMERGENCY CONTACT INFORMATION

I give permission to Simply Stars to take whatever emergency decisions are judged necessary for the care and protection of my child while at the place of service.

Please provide the name and phone number of individuals who can be called in case of an emergency when parents/guardians are not available.

Emergency Contact: _____ Relationship: _____

Home Phone Number: _____ Cell Phone Number: _____

INSURANCE INFORMATION

I understand that in some medical situations, the staff will need to contact local emergency resources before the parent/guardian, child's physician and or other adult acting on the parent/guardian's behalf.

Name of Primary Insurance: (Private or MA) _____

Member Number/MA Number: _____ Group Number: _____

Subscriber Name: _____

Name of Secondary Insurance: (If Primary insurance is private) _____

Member Number/MA Number: _____ Group Number: _____

Subscriber Name: _____

I prefer:

____ Pay my balance in full at time of service

____ Pay my balance in full upon receipt of first statement

____ Make payment arrangements prior to services being rendered

INTAKE PACKET

ASSIGNMENT OF INSURANCE BENEFITS

I understand the confidentially of my records as protected by law. Information about me/my child cannot be released without my consent. I understand I may revoke this consent at any time.

I hereby give authorization for Simply Stars to contact and inform my primary and secondary (if applicable) insurance companies of all medical information included in treatment plans relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressively agree and acknowledge that my signature on this documents authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize the Insurance Companies named above to pay and hereby assign directly to Simply Stars all benefits, if any, otherwise payable to me for his/her services. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received and paid to Simply Stars will be credited to my account, in accordance with the above assignment.

_____ _____

(Authorized signature of Subscriber) (Date)

MEDICAL INFORMATION

Hospital/Clinic Preference: _____

Client's Primary Doctor: _____ Doctor Phone Number: _____

Do we have permission to contact the Doctor?_____

Allergies: _____

List any medication routinely taken at home:_____

_____

List any medical restrictions to client's activities: _____

_____

_____

ADDITIONAL SERVICE PROVIDERS

Social Worker: _____ Phone Number: _____

Interpreter: _____ Phone Number: _____

School: _____ Grade: _____

Teacher's Name: _____ Phone Number: _____

OTHER PROVIDERS (IF APPLICABLE)

Name: _____ Type of Service: _____ Phone Number: _____

Name: _____ Type of Service: _____ Phone Number: _____

THERAPY OPTIONS

Simply Stars offers both in-home and school-based therapy for clients enrolled in our program. Please complete the form below to indicate which therapy you prefer for your child. The information you provide will help us to determine the type of therapy you are seeking for your child.

NOTE: Your insurance or your state may not allow school-based services.

Please circle: Is there a program you would not prefer or unable to participate in?

☐ YES ☐ NO

If YES, please explain:

_____

_____

Strengths

Please list all of your child's strengths such as drawing, writing, computer, etc.

_____

_____

_____

Main Concerns

Please list any concerns the child may have at home or in the community. This may include, but not limited to, sensitivity (i.e. oversensitive to noises, oversensitive to certain material or texture of food), behaviors, communication, social skills and play skills. Additionally, provide any special accommodations that would help staffs to better support the child's progress.

Possible Reinforcers

*Please list all or any preferences that your child has shown and put * next to the ones that are highly preferred in each category. Be SPECIFIC as possible!!*

Food: *(snacks, candies, chocolate – please be specific; kind or brand names)*

Toys: *(games, stuff animals, etc.)*

Activities: *(reading books, listen to music, etc.)*

_____

_____

_____

_____

Other: *(any special preferences not mentioned)*

_____

_____

_____

_____

Anticipated Schedule *(Please indicate start/end time, AM/PM)*

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

SERVICE COORDINATION

Child's Name: _____ Date: _____

SERVICE	# OF HOURS	FREQUENCY
Special Education Services		
Child Welfare- Targeted Case Management (CW-TCM)		
Community Alternatives for Disabled Individuals (CADI) Waiver		
Personal Care Assistant (PCA)		
Mental Health- Targeted Case Management (MH-TCM)		
Recreational Therapy		
Psychiatrist		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Collaborative/Wraparound Services		
Family Psychotherapy Services		
Other (explain)		

RELEASE OF CONSENT

Client Name: _____

A separate Consent for Exchange of Information form must be completed for each individual or agency you wish for Simply Stars to communicate with.

- I understand that my records are protected by data practice laws and cannot be released without my consent unless otherwise allowed by law.
- I understand that only the information and records indicated below will be released or obtained.
- I understand that this consent does not authorize the recipient of the information or records to re-disclose the information or records to any other person or facility unless authorized by law.
- I understand that the information will only be used for the purposes indicated below.
- I understand that I may withdraw or modify this consent at any time but, that the revocation or modification will not affect any release of information that previously occurred.
- I understand that the observation and/or assessment can take place in either setting.

I Authorize:

Simply Stars

simplystars@tpcaba.com

Name of Staff: _____

To obtain records from or release records to:

Name of Agency: _____

Name of Staff: _____

Type of information released:

____Assessments or evaluations

____Behavior reports

____All

____Educational records

____Medical records

____Other: _____

Information may be shared in person or by mail. I also give permission to share information using the following methods:

____Phone ____Email

____Fax ____Other: _____

____All

_____ _____

Parent or Guardian or Authorized Representatives Signature Date

Federal Law: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law prohibits disclosing this material. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

SIMPLY STARS CONSENT FORM

I, _____, as parent/legal guardian of _____, give permission for my child/ward, (hereinafter "Participant") to participate in the Simply Stars ABA services. I have received an enrollment application package and have read, understood and completed all the necessary forms required prior to enrollment. I agree with the current personal development goals established for Participant, and I am aware that I will be required to attend periodic meetings for review and revision of Participant's individual program. I also understand that I may withdraw Participant at any time. I understand that Simply Stars reserves the right to terminate the enrollment of Participant for failure to adhere to program standards.

I have given all emergency contact information to Simply Stars.

I also give permission for Simply Stars to use any necessary information and data collected on Participant to be reviewed and used in presentations at any professional meetings and conferences. I understand that Participant's name and identity will be kept confidential and will not be disclosed without prior written notification. I also understand that this will serve to further the advances in the field of autism.

I hereby agree to hold harmless and release from any and all liability, Simply Stars, its directors, officers, employees, agents, affiliates, sponsors, and promoters, as well as, their respective directors, officers, employees, and agents (hereinafter collectively known as "TPC"), for any injury or illness to the Participant, arising out of or in connection with his/her participation in TPC. Also, to the fullest extent allowed by law, I hereby waive and discharge my and the Participant's rights, including those of our heirs and assigns, to any and all claims of damages for injury or illness to the Participant, against TPC. I agree that health insurance coverage for the Participant is my sole responsibility.

Parent/Guardian comments:

_____

_____

_____

_____

_____ _____

Parent or Legal Guardian Name (Please Print) Date

_____ _____

Parent or Legal Guardian Signature Date

CLIENT NOTIFICATION OF PRIVACY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA)

Recent federal law, the Health Insurance Portability and Accountability Act (HIPAA), has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to electronic transmission of data, the keeping and use of client records, and the storage and access to health care records. HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Client Notification of Privacy Rights is designed to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can do to protect the privacy of your mental health records.

HIPAA requires that we secure your signature indicating you have received or been offered the Client Notification of Privacy Rights document.

I have accepted a copy of the Client Notification of Privacy Rights document. _____

I have been offered a copy of the document and do not wish to have a copy at this time. _____

(I understand I have the right to review the document before signing this acknowledgement form.)

_____ _____

Client's Name (Print) Client or Legal Guardian Signature

_____ _____

Client Date of Birth Date Signed

Please sign and return this page to the office. You may retain the notification document for you records.

FACE SHEET

Please complete the form below by providing as much information as possible regarding your child. This information will be given to medical personnel in case of an emergency.

Name	
Birth Date	
Parent/Guardian	
Home Address	
Home Phone Number	
Cell Phone Number	
Work Phone Number	
Primary Insurance	Name: Member Number: Group Number:
Secondary Insurance	Name: Member Number: Group Number:
Hospital/Clinic Preference	
Primary Doctor	
Allergies	
Other Information	
Simply Stars	Tennessee

Parent or Legal Guardian Signature

Date

ADDITIONAL INFORMATION

Thank you for completing the client registration packet. In addition to submitting the application packet, please include the following items when applying for enrollment:

- Copy of your child's insurance card(s)
- Medical documentation pertaining to the diagnosis of autism
- Reports from other service providers (if applicable)
    - o Speech therapy, school services, occupational therapy, etc.

Please contact the agency if you have any questions when completing the application packet, or regarding the intake process.

Thanks again,

Intake Coordinator
Simply Stars ABA
Tel: 615-981-6023
Fax: 347-212-1565
Simplystars@tpcaba.com

How did you hear about us?

_____

_____

_____

OCR HIPAA Privacy
December 3, 2002
Revised April 3, 2003

NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION
[45 *CFR 164.520]*

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any website it maintains that provides information about its customer services or benefits.
- *Health Plans* must also:
  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- *Covered Direct Treatment Providers* must also:
  - Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  - When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.

- In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
- Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

https://www.hhs.gov/hipaa/for-professionals/faq/notice-of-privacy-practice/index.html

https://www.hhs.gov/hipaa/for-professionals/faq/privacy-rule:-general-topics/index.html

You can also go to https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html **then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.**

Please Acknowledge -

Insurance companies may send payments from time to time to clients directly as opposed to the provider. In this event, you will be required to mail the checks with their EOB/EOP (Explanation of Benefits/Explanation of Payments) to 1255 E 31st street, Brooklyn NY 11210.

There may be a case when we may need to file appeals on your behalf for an insurance company to approve services or approve payment. Please acknowledge that you will work together with us on this task.

There may be a case where you will need to fill out a coordination of benefits form with your insurance company. Please acknowledge that you will do so.

Your signature below acknowledges the three paragraphs above.

X_____

ACCESS TO HEALTH RECORDS
NOTICE OF RIGHTS

This notice explains the rights you have to access your health record, and when certain information in your health record can be released without your consent. This notice does not change any protections you have under the law.

YOUR RIGHT TO ACCESS AND PROTECT YOUR HEALTH RECORD

You have the following rights relating to your health record under the law:

- A health care provider, or a person who gets health records from a provider, must have your signed and dated consent to release your health record, except for specific reasons in the law.
- You can see your health record for information about any diagnosis, treatment, and prognosis.
- You can ask, in writing, for a copy or summary of your health record, which must be given to you promptly.
- You must be given a copy or a summary of your health record unless it would be detrimental to your physical or mental health, or cause you to harm to another.
- You cannot be charged if you request a copy of your health record to review your current care.
- If you request a copy of your health record and it does not include your current care, you can only be charged the maximum amount set by Minnesota law for copying your record.

RELEASE OF YOUR HEALTH RECORD WITHOUT YOUR CONSENT

There are specific times that the law allows some health record information held by your provider to be released without your written consent. Some, but not all, of the reasons for release under federal law are:

- For specific public health activities
- When health information about victims of abuse, neglect, or domestic violence must be released to a government authority
- For health oversight activities
- For judicial and administrative proceedings
- For specific law enforcement purposes
- For certain organ donation purposes
- When health information about decedents is required for specific individuals to carry out their duties under the law
- For research purposes approved by a privacy board
- To stop a serious threat to health or safety
- For specialized government functions related to national security
- For workers' compensation purpose

Under Minnesota law, health record information may be released without your consent in a medical emergency, or when a court order or subpoena requires it. The following include some of the agencies, persons, or organizations that specific health record information may or must be released to for specific purposes, or after certain conditions are met:

- The Departments of Health, Human Services, Public Safety, Commerce, Minnesota Management & Budget, Labor & Industry, Corrections, and Education
- Insurers and employers in workers' compensation cases
- Ombudsman for Mental Health and Developmental Disabilities
- Health professional licensing boards/agencies
- Victims of serious threats of physical violence
- The State Fire Marshal
- Local welfare agencies
- Medical examiners or coroners
- Schools, childcare facilities, and Community Action Agencies to transfer immunization records
- Medical or scientific researchers
- Parent/legal guardian who did not consent for a minor's treatment, when failure to release health information could cause serious health problems
- Law enforcement agencies
- Insurance companies and other payors paying for an independent medical examination

If you would like additional information or links to specific laws, visit www.health.state.mn.us and search for "access to health records" or call the Minnesota Department of Health at (651) 201-5178.

Minnesota Statutes, section 144.292, subdivision 4 ***This notice may be photocopied.*** Revised 4/14/2009 MDH

THERE IS ALWAYS SOMETHING EXCITING HAPPENING AT SIMPLY STARS ABA!

@SimplyStarsABA

FOLLOW US ON FACEBOOK AND INSTAGRAM FOR ALL THE LATEST BUZZ!