Chitter Chatter
Center for Therapy Services

Thank you for choosing Chitter Chatter, PC as your behavioral health provider. We strive to do everything in our power to make your treatment experience as valuable for you while we help you achieve your personal goals.

You will see the attached HIPAA notice. This describes our privacy policies and how they affect you and your personal health information. Please take a moment to read this handout, but to summarize, your personal information is safe with us. We will not release any information about you unless we have your prior written permission. We also keep your chart and other records locked up or password protected so that no one can see them unless they have a need to know. If you have any questions, please ask your Behavior Consultant.

We ask that you be diligent with your scheduled ABA appointments to ensure that your child is getting the most of their ABA experience. We pledge to do the same. If unforeseen circumstances occur, and you will need to cancel or need to reschedule, we ask for 24 hours' notice. If an incident occurs that allows less than 24 hours to notify staff, be sure to contact all necessary staff immediately All canceled sessions are expected to be rescheduled whether cancelled by parents or staff. Our staff will work with you to ensure ABA hours are rescheduled in a timely manner.

As you would expect, we are responsible for ensuring the safety of our staff and participants. We ask that when our staff are present in your homes that the following situations do not take place:

- Smoking/Drinking
- Drug use of ANY kind (even if medicinal, we ask that you not partake while staff is present)
- Arguing/Marital Disputes
- Racial Profiling/Derogatory Speech
- Use of weapons

Such acts may result in dismissal from the program. The attached Discharge Criteria form also details reasons that we may ask you to leave the program. If you have any concerns about your safety, please speak to your Behavior Consultant or a program administrator.

Additionally, circumstances may arise that make your home temporarily unfit for ABA services to occur or may lead to a temporary hold on services in the center.
These include:

- Bed-bugs - If bed-bugs are seen in the home or a child presents signs of potential bed-bugs (bug bites or rash and frequent scratching around the affected area), services will be put on hold until the family can provide documentation that the home has been treated for bedbugs or that the rash/scratching were due to other non-contagious factors.
- Head Lice - If a staff member sees or suspects lice (due to frequent scratching of the head), Services will be put on hold until family can provide written documentation from a pediatrician that the condition has been treated or that the condition was not present.
- Fleas - If a home is suspected of having fleas- services will be placed on hold until family can provide written documentation that the pet/home has been treated.
- Power Outages
- Certain Illness (see attendance/cancellation section for details)

These circumstances may result in a temporary hold on services until resolved. If any of these circumstances are discovered during session, the parent/guardian of the child will be called for an early pick up. Please speak with your Behavior Consultant what to expect if any of these circumstances occur and what steps should be taken.



*Please initial: I have read and understand the contents on this page.* _____
*Questions/Concerns were directed to Chitter Chatter staff and explained to me directly* _____

We want your experience here to be a positive one. If you have a complaint or would like to see a different Behavior Consultant please contact Manal Rizk program administrators with your concern. If you would like to request a new ABA therapist please speak with your Behavior Consultant about your concerns. We will do our best to resolve your complaint as quickly as possible. If you do not feel that your complaint has been resolved adequately, you may have additional rights. Members of the MCPN system in Wayne or Oakland counties, you can appeal through the agency in which you belong, or to the MCPN directly. If you are a WCHO member, you can file a complaint directly with the WCHO customer service department.

Thanks for choosing Chitter Chatter, PC.



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Chitter Chatter
Center for Therapy Services

# Fire Drill and Other Emergencies

The safety and welfare of our consumers and staff are our highest priority. To provide Chitter Chatter P.C. centers with the opportunity to practice emergency response procedures, it is necessary to conduct security drills as well as fire drills. Each month the center must conduct one fire drill and one security drill which may be a lockdown, bomb threat, evacuation, active shooter, or shelter in place drill. **Some of these drills will require us to take your consumer/child outside of the building to a designated location for emergency evacuations.** The company is required by law to implement this procedure.

Chitter Chatter is working diligently to ensure that these procedures are implemented correctly. Our staff members have all been trained in our emergency drill procedures and are well prepared should we have to deal with a real emergency. The goals of the training drill are to improve our ability to protect our consumers, save lives, and reduce injuries. They also allow us to evaluate our emergency operations plan and improve our response skills.

In order to protect consumers, in case of an actual emergency consumers will only be released to the parents and/or other adults listed on the emergency information sheet. Please be sure that this information is current and accurate. It is a good idea to have several trusted adults listed in the emergency information sheets.

This letter serves as notification that Chitter Chatter P.C. will be conducting these drills in accordance with State of Michigan regulations and guidelines. The dates and times of these drills will not be announced. You would only be notified if there were a real emergency.

If you have any questions or need further information please do not hesitate to contact our center at 313-689- 5188 for Wayne County or 734-682-5174 for Monroe County.



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Chitter Chatter
Center for Therapy Services

## Camera Notice

In an effort to have a more efficient and less disruptive form of observation of our consumer's during session, Chitter Chatter P.C. is installing cameras in every therapy room in all of our centers.

The safety and welfare of our consumers and staff is our highest priority. Therefore, cameras will be used for the purposes of observation only and access to the footage will be limited to Chitter Chatter P.C. ABA supervisory and managerial staff.

This serves as notification that Chitter Chatter P.C. will be installing cameras in their therapy rooms in accordance with all Heath Information Portability and Accountability Act (HIPAA).

If you have any questions or need further information please do not hesitate to contact our center at 313-689- 5188 for Wayne County or 734-682-5174 for Monroe County.



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Chitter Chatter
Center for Therapy Services

**In-Home ABA Program Intake Packet**
**CHILD & ADOLESCENT INTAKE QUESTIONNAIRE**

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information, which you think, may be helpful in understanding your child. Chitter Chatter PC will hold information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information. **PLEASE PRINT.**

Name of Person Completing this form: _____
Driver's License Number: (please be sure to get a copy of document)_____
Legal Name of Child/Adolescent: _____
Nickname or name child routinely goes by: _____
Child's Date of Birth: _____ Age: _____
Home Address (include county): _____

| **Relative** | **Personal Phone** | **Home Phone** | **Work Phone** |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Other | | | |

School Name: _____ System: _____ Grade: _____
School Telephone Number: _____
Current Teacher(s): _____
Who referred you to our practice?
_____

Please describe the problems your child is now having, and what type of services you are seeking from us for these problems. Please use the back of this page for additional space.
_____
_____
_____
_____
_____

**INDICATE PARENT/GUARDIANS LIVING IN THE HOME:**
Marital Status: Married – Remarried – Divorced – Separated – Widowed – Single – Cohabitants
• If divorced, who has physical custody? _____
• Is it full or joint? _____
• Who has legal custody? _____
• Is it full or joint? _____
• If divorced, please provide a copy of the custody agreement.
Mother's Name _____
Date of Birth: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Email: _____
Education Completed _____
Health: ___Excellent ___ Good ___ Fair ___ Poor



*Please initial: I have read and understand the contents on this page.* _____
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Does parent's job require him/her to be away from home long hours or extended periods? (if yes, explain)

_____

_____

Father's Name _____
Date of Birth: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Email: _____
Education Completed _____
Health: ___Excellent ___ Good ___ Fair ___ Poor
Does parent's job require him/her to be away from home long hours or extended periods? (if yes, explain)

_____

_____

**Siblings:**

| **Name** | **Age** | **Does sibling live with client?** |
|---|---|---|
| | | |
| | | |
| | | |

**Additional Information About Home/Living Conditions**

**Languages spoken in the home:**

| | |
|---|---|
| **Primary:** | |
| **Other:** | |
| **Other:** | |

***Please inform your Behavior Consultant if you are in need of a translator for parent meetings or explanations of treatment.**

**Additional People in Home:**

| **Name** | **Age** | **Relationship to client** |
|---|---|---|
| | | |
| | | |
| | | |

**Who in the home (other than primary caregiver) is able to ask/receive information regarding client's treatment? (Please list all who apply, if none please list as "Only primary caregiver".**

| **Name** | **Relationship to client** |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Please list if there are any pets in the home:**

_____



*Please initial: I have read and understand the contents on this page.* _____
*Questions/Concerns were directed to Chitter Chatter staff and explained to me directly* _____

_____
_____

**If yes, where will they be kept during ABA:**

_____
_____
_____

**PSYCHOLOGICAL HISTORY:**
Is there a history in your immediate or in the mother's or father's extended family, or the following and if so who?

| **Diagnosis** | **Yes** | **No** | **Relation** |
|---|---|---|---|
| Autism Spectrum Disorder | | | |
| Learning Disabilities | | | |
| ADD/ADHD | | | |
| Depression/Manic Depression | | | |
| Behavioral Problems in School | | | |
| Anxiety Disorder | | | |
| Intellectual Disability | | | |
| Psychosis/Schizophrenia | | | |
| Substance Abuse/Dependence | | | |
| Other relevant medical concerns (Please list below) | | | |

_____
_____
_____

Has the child you are seeking services for been evaluated in the past? Yes/No

If Yes, please list the following information on the previous evaluation(s)

| | |
|---|---|
| Evaluated by: | |
| Type of Services/Evaluation: | |
| When Evaluation Occurred: | |
| Did client receive services (if yes, what and how long?) | |

(If more evaluations need to be listed please use the space on the back of this page.)

If yes, what were their general findings and recommendations?

_____
_____ _____
_____
_____

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child:

_____



*Please initial: I have read and understand the contents on this page.* _____
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_____
_____
_____

**PRE-NATAL AND DELIVER HISTORY:**
Were there any complications with the Pregnancy? Y/N

If Yes, please provide treatment details:

_____
_____
_____

Was birth at Full Term? Y/N

If No, please provide details:

_____
_____

Type of Delivery: Spontaneous/Induced Vaginal/C- -Section
Complications? Y/N
If Yes, please provide details:

_____
_____
_____

Birth Weight: _____ lbs _____ oz
Concerns at Birth? Y/N
If Yes, please provide detail – including any treatments given (Additional space on back if needed):

_____
_____
_____
_____

Is there any additional pre- -natal or birth information that might be of assistance to us?

_____
_____
_____
_____

**DEVELOPMENTAL HISTORY:**
Please indicate the age at which your child did the following:

Rolled over consistently _____
Sat up unsupported _____
Stood _____
Crawled _____
Walked Unassisted _____
Said 1st Word Intelligible to strangers _____
Said two- -three word phrases _____
Used Sentences regularly _____



*Please initial: I have read and understand the contents on this page.* _____
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Toilet trained during the day _____
Dry through the night (6+ months) _____
Dressed Self _____
2. Please indicate if your child is experiencing any of the following:
Problems with eating _____
Isolated socially from peers _____
Problems making friends _____
Problems keeping friends _____
Problems getting to sleep _____
Problems controlling temper _____
Nightmares _____
Bed Wetting / Soiling _____
Problems with authority _____
Anxiety _____
Unmotivated _____
School concentration difficulties _____
Grades dropping or consistently low _____
Sadness or Depression _____

3. List any operation, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

_____
_____
_____

4. List any medications your child is currently taking or has taken for extended periods (give dosage level if possible): _____
_____
_____

5. Child's current height: _____Ft. _____Inches Weight: _____Lbs.
6. With which hand does the child write:

_____

7. Does the child have any vision problems?

_____

Please list date of last vision test and who performed (pediatrician, optometrist, School)

_____
_____

8. Does the child have any hearing problems?
Please list date of last hearing test and who performed (pediatrician, optometrist, School)

_____
_____

9. Name of child's physician(s)

_____
_____

Practice Name: _____

Address: _____
_____



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Phone Number: _____ Fax Number: _____
(Please list information on additional Physicians on the back of the page)

**EDUCATION HISTORY:**
1. List in chronological order all school's you child has attended:

| School Name/Location | Grades Attended | Additional Services Provided (Sp. Ed, OT, PT, Speech) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

2. Name(s) of current teacher(s) _____
3. Does your child's teacher have concerns about him/her (list) _____
_____
_____
4. What is your child's favorite subject/class?
_____
_____
5. What is your child's least preferred subject/class?
_____
_____
6. Has your child ever repeated a grade? Y/N If yes, what grade(s)?: _____
7. If your child has been in Special Education, did they have a:
• 504 Plan
• I.E.P.
• Psychological Evaluation
• Special Evaluation
• Behavior Intervention Plan
• Occupational Therapy Evaluation
• Physical Therapy Evaluation
• Adaptive Technology Evaluation

8. If your child has been in Special Education, how were they served?
_____
_____
_____
_____

9. Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:
_____
_____
_____
10. List any special abilities, skills, strengths your child has:
_____
_____
_____



*Please initial: I have read and understand the contents on this page.* _____
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**GENERAL INFORMATION:**

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sister, etc.

Like Child to do More Often

1. _____
2. _____
3. _____
4. _____
5. _____

Like Child to do Less Often

1. _____
2. _____
3. _____
4. _____
5. _____



*Please initial: I have read and understand the contents on this page.* _____

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Chitter Chatter
Center for Therapy Services

**INFORMED CONSENT FOR BEHAVIORAL SERVICES:** I hereby voluntarily apply for and consent to services by Chitter Chatter P.C. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize the release of information, or under certain other conditions listed below:

- Where abuse or harmful neglect or children, the elderly, or disabled or incompetent individual is known or reasonably suspected
- Where such information is necessary for the company to pursue payment for services rendered
- Where an immediate threat of physical violence against a readily identifiable victim is disclosed to the therapist
- Where the client is examined pursuant to a court order.

I hold Chitter Chatter PC harmless for releasing information under the above conditions.

_____
Childs Name

_____
Parent/Guardian Name

_____
Signature of Parent/Guardian Date



*Please initial: I have read and understand the contents on this page.* _____
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**REINFORCEMENT ASSESSMENT FORM**

Prior to beginning the pairing process, it is important to identify ALL of your child's motivators or reinforcers. Many students have very specific reinforcers and may engage with them in certain ways. Please provide as much detail as possible.

Please indicate your student's preferences below. Please provide specifics if possible (e.g., what kind, brand, type, etc.).
What are your student's preferences (likes and dislikes)?

_____
_____
_____
_____
_____

Sensory Preferences: (be sure to include likes AND dislikes)

_____
_____
_____
_____

What are your student's entertainment preferences?

_____
_____
_____
_____

What are your student's favorite snacks/foods?

_____
_____
_____
_____



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Chitter Chatter
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## RELEASE OF INFORMATION

Patient Name: _____ Medical Record Number: _____
Date of Birth: _____ Account Number: _____
SSN: _____ Phone Number: _____

1. I authorize the use or release of the above named individual's health information as described below is authorized to release information:_____
Address:_____

2. The type and amount of information to be used or released is as follows: (check those that apply and include dates where appropriate)
_____School Observation, Consultation and/or conference with Teacher/Staff
_____Discharge Summary from (date) _____ to (date) _____
_____History and Assessment from (date) _____ to (date) _____
_____Consultation from (date) _____ to (date) _____
_____All Consultations from (date) _____ to (date) _____
_____Billing Information from (date) _____ to (date) _____
_____Home Health Record from (date) _____ to (date) _____
_____Entire Record from (date) _____ to (date) _____
_____Other_____Other_____

3. I understand that the information in my health record may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be released to and used by the following individual or organization:
_____
Address: _____
For the purpose of: _____

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to PsychSystems PC. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

6. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or released, as provided in 45 C.F.R. 164.524. I understand any release of information carries with it the potential for re-release by the recipient and once authorized to be released, the information may not be protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Relationship to Patient

_____ _____ _____
Printed Name of Witness #1 Signature of Witness #1 Date

_____ _____ _____
Printed Name of Witness #2 Signature of Witness #2 Date

THIS RELEASE MUST BE SIGNED BY AT LEAST ONE WITNESS. TWO WITNESSES ARE REQUIRED IF THIS STATEMENT HAS BEEN SIGNED BY A MARK (X).



*Please initial: I have read and understand the contents on this page.* _____
*Questions/Concerns were directed to Chitter Chatter staff and explained to me directly* _____

**Scheduling Information**

Note that, for center based consumers, it is very likely that at any given time during their drop off, pick up, at our center locations, they may encounter other families or individuals who may or may not be a part of the Chitter Chatter organization. This may also be true throughout the day as they frequent common building areas such as the lobby or hallways. This is not in violation of any HIPAA regulations. Chitter Chatter will abide by all HIPAA regulations and Guidelines at all times.

**Please indicate the days of the week that you are available for scheduled ABA therapy. Please contact your Behavior Consultant with any questions about scheduling. If you have already set up a schedule with your technician/behavior consultant please indicate this in additional comments.**

**Please take the following into consideration when deciding a therapy schedule for your child:**

1. **Chitter Chatter can provide therapy for a minimum of 15 hours per week (unless otherwise approved by the ABA program manager),**
2. **Chitter Chatter will provide a minimum of 3 hours per session**
3. **Chitter Chatter will provide a minimum of 4 sessions per week.**
4. **All desired hours for therapy shall remain in the same time block for every day that your child will receive services.**
    a. **The time blocks are as follows**
        i. **Block 1 - 8:00 AM - 12:00 PM**
        ii. **Block 2 - 12:00 PM - 4:00 PM**
        iii. **Block 3 - 4:00 PM - 8:00 PM**
    b. **If your child receives more than 4 hours of services per day, the scheduled hours can extend into a second time block, but the hours should be consistent throughout the week.**

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| **AM** | | | | | | | |
| **PM** | | | | | | | |

**Please indicate times in addition to scheduled ABA session times that you would be available for make-up hours to be completed. We ask that you are available for potential make-up hours at least 1 hour per week in addition to your scheduled ABA hours. For questions regarding make-up hours procedures please speak with your Behavior Consultant.**

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| **AM** | | | | | | | |
| **PM** | | | | | | | |

**Sub Information**

In the event that the staff assigned to your case is unable to attend a scheduled session, they will be asked to attempt to find a substitute to cover their session. Though we hope that this is not a common occurrence, Chitter Chatter would like to know any preference that you may have for subs in advance. If specific considerations need to be made in choosing subs to cover your shifts please notify your behavior consultant as soon as possible. Please keep in mind that if you refuse a sub worker, you are expected to work with your Behavior Consultant and Technician to schedule make-up hours in addition to your scheduled ABA session times.



*Please initial: I have read and understand the contents on this page.* _____
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Please list any sub preferences/considerations in the space provided

_____
_____
_____
_____

*If you are not comfortable with having substitute technicians, please communicate your concerns with your Behavior Consultant as soon as possible.

**General Consent to Treatment**

1. Release of Information

Psychological and social services information including communications made by me to a psychologist or social worker to:

a. Any third party payer or insurance company (including Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers' disability compensation insurers, health maintenance organizations, preferred provider organization, and managed care plans) which are responsible in whole or in part for paying my health care bill so that the Facility may be paid for its services;

b. Any healthcare facility or physician to which I am referred or transferred for continuity of care~ and

c. Any independent auditors or reviewers retained by the Facility, any third-party payer, private health insurer or any employee providing health insurance benefits to me so that these independent auditors can analyze Facility utilization and/or charges.

d. My current potential employer, if the purpose of the medical examination and/or treatment arises from or pertains to my current or prospective employment, e.g., an employment physical or care and treatment arising from a workplace injury.

This release authorization shall be effective only so long as is necessary to accomplish the purpose for which it is given. With respect to substance abuse information (if any), this consent may be revoked at any earlier time unless the Facility has already released information in reliance upon it.

2. Benefits of Treatment- No Guarantees or Assurances

This facility has made no guarantee or assurances about the results of my treatment. I understand that a client will receive the usual and ordinary care rendered in this community, and that no other contract, written or implied, is made. I have been adequately oriented to the services that Chitter Chatter P.C. provides and have been able to ask questions regarding my expectations and desires for treatment and possible outcomes.

While we cannot guarantee therapy outcome, we will provide the following services to increase the probability of the best outcome:

- We will provide a written document of the treatment plan to assist caregivers (when indicated)
- We will teach others how to implement the strategies via an in-service and periodic feedback to staff/families
- We will provide direct therapy and/or skill training to you or your child/ward when indicated.
- We will provide indirect assistance (meeting attendance, documentation to other parties) when indicated.



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Our goal is to provide benefit to help you or your child/ward ameliorate challenging behaviors or to learn skills to help you or your child/ward improve their quality of life.

* * Facility: The term "Facility" is just a convenient description and does not suggest or create any relationships between the above listed entities.

**Payment Provisions**

Note: The term "health care benefits" in the following paragraphs mean Medicare, Medicaid, maternal and infant health, Blue/Cross Blue Shield, commercial health insurance benefits, automobile no-fault benefits, workers' disability compensation benefits, health maintenance organization, preferred provider organization, or managed care plan coverage, as applicable.

3. I understand that, except in limited circumstances, separate billings will be issued for services of the Facility and services of physicians, and that neither charges are included in the billings of the other.
4. I request payment on my behalf of all health care benefits for services provided by the Facility and by physicians for whom the Facility is authorized to bill.
5. I assign and transfer to the Facility all health care benefits applicable to my care, including those health care benefits listed on the first page of my medical record. I authorize and direct that all such health care benefits be paid directly to the Facility.
6. **I agree personally to pay for any Facility or physician charges not covered by or collected from any applicable health care benefits program, including any deductibles and coinsurance amounts.**

**7. NO SHOW to appointments made by private pay or Insurance funded clients will be charged a fee of at least $40.00. Please call at least 12 hours in advance to cancel any appointment.**

Note: Please advise that the Facility may request an HIV test upon a patient without any special written consent if a health professional, health facility employee, police officer, fire fighter, medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic who sustains in the health facility, while treating the patient before transport to the health facility, or while transporting the patient to the health facility, a percutaneous, mucous membrane, or open wound exposure to the patient's blood or other bodily fluids or the HIV test is performed pursuant to a request under MCL *33.20191* (2).



*Please initial: I have read and understand the contents on this page.* _____
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*Please initial: I have read and understand the contents on this page.* _____
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Chitter Chatter
Center for Therapy Services

**Chitter Chatter Fee Scale - Adjustment for Income Level**

| | Full Fee | Low Income Fee |
|---|---|---|
| Individual Therapy: | $100/Session | $50/Session |
| Assessment/Evaluation: | $100/Hour | $50/Hour |
| Group Therapy: | $20/Person/Session (minimum 3 people) | $15/Person/Session |
| Family Therapy: | $85/Session | $40/Session |
| Psychological Testing and Formula Evaluation: | $100/Hour | $50/Hour |
| No Show: | $40/Occurrence | $40/Occurrence |

Note: Chitter Chatter, P.C. will bill Blue Cross/Blue Shield, Blue Care Network, or other insurances for psychological assessments and treatment services whenever possible. Psychiatric services may also be billed to medicaid for applicable charges.

This fee scale is subject to change and will not be binding on any part, unless listed as an attachment to a formal service contract.

_____ _____

Parent/Guardian Signature: Date:

Family income must be below the federal poverty level. This does not apply if the client is fully supported by Medicaid "carve out funds" from a community mental health agency or is living in a fully supported group home or other supported living situation. A supports coordinator/social worker or other representative must apply and be accepted by Chitter Chatter, P.C. to receive this fee adjustment.



*Please initial: I have read and understand the contents on this page.* _____

*Questions/Concerns were directed to Chitter Chatter staff and explained to me directly* _____

Chitter Chatter
Center for Therapy Services

**Client Acknowledgment**

By my signature, I confirm that I have been informed of program practices, policies, and procedures as listed below:

I. Program goals and objectives, hours of operation, and fees charged.

2. I have received a copy of my recipient rights and notice of confidentiality and I understand them. I understand I will participate in the development of my treatment plan. I have also received a copy of program policies which may restrict certain rights.

3. I have been informed of and have received a copy of program discharge policies.

4. At my request, I have had an opportunity to review a listing of services which I may receive through referral to other agencies.

*5.* I understand that I must request any written progress reports at least one week in advance of when needed.

6. I understand that I am liable for payment of the fees for therapy/treatment, regardless of my insurance coverage. It is my responsibility to determine what portion of the fees are covered by my insurance, and the duration of the coverage of my insurance. I have received a copy of the fees for services schedule, or have been informed of all outpatient rates.

7. I will be charged a "no show" fee for any appointments that are not kept or canceled at least 24 (twenty-four) hours prior to the appointment. Furthermore, I understand that third party insurance's do not cover "no show" and "late cancellation" fees and I am fully responsible for these fees.

8. I understand that it is my right to request changes in therapists or to be referred to another agency who can treat my condition. Chitter Chatter assures me that no retaliation nor any other consequence will occur regarding any request of this type.

AUTISM program Video observation consent

9. I also understand that my child, by participating in the Autism Program, will be videotaped or observed 'live' by use of computer technology. You agree to allow this technology to be used with your child and, if your child is enrolled in the In-Home Autism program, you agree that we may video tape or observe your child and the surrounding area of your home. Video clips and live observations will be kept confidential and technology used to generate these experiences will be HIPAA compliant. _____ (initial). I give Chitter Chatter permission to allow videos taken of my child's therapy session to be used for training of staff. Video clips and live observations will be kept confidential and technology used to generate these experiences will be HIPAA compliant _____(initials)

10. Autism program visitation consent. At times, members of the community (including funders, visiting prospective parents and Chitter Chatter personnel) may visit the Autism Center. You agree to allow this to occur without special consent during each visit. All specific client related data will be kept secure during these visits.



*Please initial: I have read and understand the contents on this page.* _____
*Questions/Concerns were directed to Chitter Chatter staff and explained to me directly* _____

Chitter Chatter
Center for Therapy Services

**Notice of Independent Contractual Therapist status**

Many therapists (except the agency Co- Executive Directors or other employed therapy staff who may also act as therapists) are independent contractors of Chitter Chatter. This means that these individuals have agreed to practice under the clinic policies and procedures and professional ethical standards, but otherwise make treatment and other clinical decisions on their own. If you have any questions regarding how this relationship may affect your care, please ask to speak to an administrator.

**Discharge Policy**

Discharge from Chitter Chatter P.C. treatment may occur for any of the following reasons:

1. Completion of prescribed treatment and progress toward achievement of goals.

2. Inability to comply with the structure of the program including:

    a. non-compliance with program rules

    b. habitual non-compliance with treatment plan

    c. possession of alcohol or drugs

    d. threat or action of physical violence

    e. unauthorized weapons

    f. inconsistent attendance as evidenced by:
        1. failure to show for four (4) scheduled appointments.

        2. canceling more than **1/2** of the scheduled appointments in a six (6) week period.

        3. No response to calls from the therapist or the office staff, or no response to correspondence from the office indicating our intent to close the case.



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Chitter Chatter
Center for Therapy Services

Additional Consent to treatment information and notice of Recipient rights and Grievance and Appeal information- For CMH funded clients

I give Chitter Chatter P.C. permission to provide the following service(s): Psychobiological assessment and related treatment (including but not limited to: group therapy, ABA therapy, Treatment planning)

I understand my consent may be withdrawn by me verbally or in writing at any time. This consent will continue to be in force for as long as treatment services are provided and will end at the time that treatment services are discontinued. I also understand that me or my child may be video recorded for treatment purposes. This video will be kept on a HIPAA compliant server and will only be viewed by professionals with a 'need to know'.

Notification of Recipient Rights:

I have been given a copy of "YOUR RIGHTS IN MENTAL HEALTH", and received a summary of my recipient rights (Recipient's Bill of Rights) which I fully understand. These documents have been read and discussed with me by staff at my MCPN agency (Synergy, CLS, WCHO, etc)

I have also been given (at my agency) a copy of "Advance Directives for Medical and MH Care" and discussed it. I have been adequately oriented to the services that Chitter Chatter P.C. provides and have been able to ask questions regarding my expectations and desires for treatment and possible outcomes.

Notification of Grievance and Appeal Rights:

It is the goal of Chitter Chatter to provide our consumers with a system to express and receive a response to any grievance they may have regarding services provided by Chitter Chatter.

It is your right, as a consumer, to file a grievance or formal complaint about the treatment you are receiving from Chitter Chatter. A grievance is an issue of concern about some aspect of the services you receive that you wish to resolve. If you feel that you have been unable to resolve your issues/concerns with your treatment team, we encourage you to file a grievance report.. You may make your grievance report to your therapist, technician, case supervisor or any other staff member. We guarantee that we will respond to your grievance within 7 business days for a non emergency situation.

**Procedure:**

1. The customer submits written or verbal complaint to staff. The staff member receiving the grievance will assist the consumer in filling out the grievance form if assistance is needed.
2. The staff will then submit the report to the department manager within 2 business days of receiving it, for review and action.
3. The department manager will provide the consumer with the investigation findings and a response to the consumer, in person, by phone, or in writing, within 5 business days.
4. If the grievance is not resolved via the program manager, the clinical director will review the grievance and will respond to the consumer within 5 business days in person, by phone, or in writing.
5. If the grievance still remains unsolved, the clinical director will forward the concern to the CEO for final resolution. The consumer will be notified in person, by phone, or in writing of the results of the review.
6. The total processing time will occur within 30 business days from the initial grievance date.
7. Consumer grievance forms will be available at the reception desk.
8. Additional consumer resources include:
    a. Detroit-Wayne Mental Health Authority - 313-344-9099



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b. Michigan Department of Health and Human Services - 517-373-3740

9. A consumer grievance will not affect the availability of services to that consumer.
10. The Director of Compliance will receive a copy of all grievances filed.
11. The Director of Compliance shall maintain a record, per Chitter Chatter Policy on Record Retention of grievances and their resolutions.



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Chitter Chatter
Center for Therapy Services

## Grievance Report

**Name of Person Making the Report** _____

**Telephone Number Where You can be reached** _____

**Are you the Primary Consumer? Yes____ No____**

**If not primary consumer, please explain relationship to client:**_____

_____

_____

**Name of Consumer:** _____

**Consumer's Date of Birth (for ID purposes):** _____

**Date of Report:** _____

**Nature of Grievance:** _____

_____

_____

_____

**Location of Office to Which Grievance Pertains:**_____

**Personnel Involved:**_____

_____

**Referred to:**_____

**Date of Referral:**_____

**Resolution:**_____

_____

_____

_____



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**Acknowledgement**:

I have the right to file a grievance or appeal if I am not satisfied with my services. If I choose to do this, the program staff and/or management may not inflict any retribution or any other related consequence to me.

I have the right to a person-centered treatment plan and services.

If I am not satisfied with my Individual Plan of Service or any aspect of my service, I may discuss my concerns in person with my Supports Coordinator/Personal Agent or by calling my MCPN or CMH Customer Service Department. You may also call Chitter Chatter P.C. for assistance with this process at 313-689-5188. My concerns or grievances will be acknowledged and responded to in writing by the person who discussed them with me.

I also understand that I have options regarding my treatment and the person who provides treatment to me or my child/ward as follows:

- I can request a different therapist from your group
- I can request to be referred to another qualified provider that contracts with the CMH
- I can seek out services in the general community
- I can choose not to receive treatment at this time.

Chitter Chatter P.C. will help me achieve my treatment goals by providing:

- Written documentation of the treatment plan (if one is developed)
- Periodic in-service training and coaching of the strategies in the plan
- Direct treatment such as individual therapy or training services
- Indirect services like attendance at meetings.

The benefit of working with one of our therapists/technicians is not guaranteed, but we will strive to help you or your child cope with problematic symptoms and/or learn skills that will help them achieve a positive quality of life.

I understand that, I have a right to speak to the Grievance and Appeals Coordinator and to file a local appeal of any service denial. And my support team will monitor my life situation during scheduled visits during which time I may discuss any problems or issues with them. In addition, my PA/Supports Coordinator will discuss on a regular basis my level of satisfaction with services provided to me.



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Chitter Chatter
Center for Therapy Services

**Autism program attendance policy**

Regular attendance/ participation with the child's Applied Behavior Analysis (ABA) treatment is essential to ensure uninterrupted progress and to enable children to reach their potential. We expect all enrolled children to attend/be available for the program ***on time*** and ***every day that treatment is available***

The following table will identify the percentage of attend/be available for and the expected level of benefit a parent can expect regarding their child's progress:

| | |
|---|---|
| 92%+ | **Excellent attendance/participation**– Well done! This will help all aspects of their progress. This will maximize their learning opportunities. |
| 86-91% | **Good attendance/participation** – Well done, strive to build on this. |
| 76-85% | **Satisfactory attendance/participation**- Absence may be affecting attainment and progress in treatment. Please work with Chitter Chatter staff for make-up hours and your supports coordinator to improve the situation. |
| Below 75% | **Unsatisfactory attendance/participation** – Absences are a SERIOUS CONCERN. The number of sessions missed are affecting attainment and progress and is disrupting your child's learning. We will work with you and the Support Coordinator to improve attend/be available for. ****Continued unexcused absences from treatment will jeopardize your child's program slot in the Autism Program** |

**** As a general rule, any child who attends/is available for treatment less than 75% of his or her scheduled sessions for 2 consecutive weeks and/or persistent lateness (more than 30 minutes without prior warning) for at least (4 out of 8 treatment days) will be considered for discharge.**

**A meeting with the Supports Coordinator and the parent will be convened at this time to insure that the child's attend/be available for will improve during subsequent weeks. If the child's attendance/availability continues to be below 75% for an additional 2-week period, the child will be discharged from the program and would require reapplication to the program before being allowed to re-enter.**

**General procedures for the Chitter Chatter Autism Program**

**Autism Center-** Arrival and Registration

All children should be ready for their session to begin five minutes prior to their scheduled treatment time. Parents are expected to call if there are any circumstances that will prolong the start of scheduled treatment (woke up late, bus running late, traffic etc.). Postponing treatment more than 10 minutes late without a call is recorded as an un-authorized late mark. An unexcused late arrival time of more than 15 minutes will result your child not being accepted for treatment for that day. Please contact your support coordinator if you have problems with transportation or other barriers to getting your child to the Program at the scheduled date and time.

**In-Home treatment program**

It is expected that the child and at least 1 responsible adult (someone over the age of 18) will be present at the home at the time that the Technician is expected to arrive and should be present throughout the duration of the session. . IF a problem arises that would cause the parent/caregiver to be late, a call to the Technician is expected. If you are not present at the time that the Technician arrives, they will wait up to 15 minutes before they leave. It is also expected that a Technician will be allowed to work each time that they arrive on a scheduled day and time. IF either of these occasions occur 3 times in a 90-day period, a meeting with the parents and the Supports Coordinator will be arranged to determine if the child's case will be closed.



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***** Please note that a parent or guardian who is at least 18 years or older, must be present throughout the entire duration of therapy sessions being conducted in the home setting. A parent or guardian who is 18 years or older must also be present during the entire duration of any community outing that is to take place as a part of therapy. At no point, will a technician be allowed to enter or stay in a home when there is not a parent or legal guardian who is 18 years or older present.

Illness and Medical Appointments

When a child is unwell, parents should contact staff *before 9:00 am* on the first day of absence informing staff of the reason for the absence. If we do not receive a phone call or message telling us that the child will not be in that day staff will assume that treatment is occurring and show up for their scheduled session. Continuous failure to alert appropriate staff of absences prior to session may result in discharge from ABA program. *NOTE: If your child has a chronic illness that may cause your child to miss treatment more than would normally be expected, we would request a Doctor's note or other documentation of this fact. In these cases, modifications to this policy may be required.*

To further insure that your child attend/be available as often as possible:

a) Every effort should be made to arrange medical appointments outside program hours.
b) If it is unavoidable that your child attend/be available for an appointment during program hours, please provide proof (a card or verification by the doctors/ dentist/hospital) to ensure that this absence is registered as an excused absence.
c) If your child is absent due to vomiting, diarrhea or a fever they should not return to the program for **the next 24 hours** after the vomiting, diarrhea or fever has stopped. This is to reduce the risk of infection to other children and adults at the program.
**Note that Chitter Chatter P.C. considers a temperature of 100.4 or more as a fever and will request that the child is picked up immediately in such situations.**
d) IF the child misses treatment for more than two days we require a written explanation of why the child was absent and a phone call at least 24 hours before the child is expected to return for treatment.

Other reasons for absences

Chitter Chatter PC Autism Program may allow excused absences for family holidays for up to 10 treatment days a year in **special circumstances. For this to occur, we must have an advance request from the custodial parent.**

***Possible reasons that Chitter Chatter may not offer treatment on a particular day:***
***Severe Weather Cancellations:***

***Power Outages:***

- If your home is experiencing a power outage, services are to be cancelled until power is restored. If the a power outage occurs during a scheduled ABA session and remains out for 30 min, it is up to the behavior technicians discretion whether or not to continue services that day.

*If you live in an area where power outages result in inability to use the restroom/facilities until power is restored the session should be discontinued until power is restored.

**Inclement Weather**

- Chitter Chatter will **not** be closing due to inclement weather.. If the schools are canceled due to *cold weather* please do not assume that the program is closed. Technicians are expected to show up for their scheduled shifts.
    - If you are receiving services in the center, and would like to cancel the session due to inclement weather, please contact (text or phone call) your child's Behavior Technician **and** Behavior Consultant **no later than two hours before your child's ABA session** to let them know if you would like to cancel or participate in treatment that day.



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- **Please note: Cancelling when conditions are safe for a Technician to get to a home or for a child to get to the Autism Center may be considered an Unexcused Absence.**

❖ If your child will be receiving ABA treatment during severe weather, please make sure that a **parking spot has been cleared of snow/debris and is available for your Technician.**

**Client Cancellations due to Illness:**
Clients are expected to cancel session in the event of:

- Any person in the home has experienced gastrointestinal symptoms (vomiting, diarrhea, etc.) within the last **24 hours.** Must be symptom free for at least 24 hours before ABA can resume
- Any children in the home have had fever symptoms in past 24 hours
- The client has been diagnosed contagious, even if currently on medication (pink eye, chicken pox, Strep etc.) Must provide Dr. note for when ABA may resume
- If **any** person in the home has head lice
- If the home has bedbugs or fleas (must treat before ABA can resume)

*** If technician arrives to session and any symptoms listed above are present or become present, technician is to contact BCBA and discontinue session immediately.**

**Holiday Procedures**

Technicians are not required to work on the Holidays listed below. If you request services on a Holiday and the technician is unable to provide the services the technician will attempt to schedule for a sub to attend the shift. If there is nobody available to do a sub shift, work with your technician and Behavior Consultant to schedule make-up hours outside of your scheduled ABA session.

**List of Holidays**

1. New Year's Day
2. Martin Luther King Day
3. Memorial Day
4. Independence Day
5. Labor Day
6. Thanksgiving Day
7. Christmas Day

If your family observes Holidays that are not listed above, and need to cancel services for the day, please notify your Behavior consultant and technician as soon as possible.

***Technician Tardiness and No Call/No Shows:***

**Technician Late Arrival:**

- Your child's Behavior Technician is expected to arrive **on time** for all scheduled ABA treatment sessions. Please let us know if this does not occur.
- You will be contacted if your child's Technician is running **five or more minutes late**. Every effort will be taken to make up any lost time due to late arrival. If possible, allow the technician to extend the session to make up for the time missed.



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- If you were not notified of late arrival and your child's Behavior Technician has not yet arrived (running five or more minutes late), please contact both the Behavior Technician and Behavior Consultant for an estimated time of arrival.
- Please contact the Behavior Consultant **immediately** in the event of a "no call/no show" or any unexplained severe tardiness.

**Late Start or Early Dismissal:**

- Your child's ABA treatment session is expected to occur **at the scheduled time**. At times, unforeseen circumstances may occur which may cause a Technician to arrive late or need to reschedule their session. When this occurs, we appreciate your flexibility in working out the details of the incident at hand.
- Late arrivals or other schedule disruptions should not be a frequent occurrence. If you feel that the Technician is not keeping to their schedule, please discuss the issue with the Technician, Behavior Consultant and the Chitter Chatter Autism coordinator **as soon as possible.**

Questions? Please call the program Administrative offices at (313)-689-5188 or speak to your Technician or Behavior Consultant.

IF YOU WOULD LIKE A COPY OF OUR FULL ATTENDANCE POLICY, PLEASE REQUEST ONE FROM THE CHITTER CHATTER ADMINISTRATIVE OFFICE AT (313)-689-5188



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Chitter Chatter
Center for Therapy Services

**THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**

PLEASE REVIEW THIS INFORMATION CAREFULLY
NOTICE OF PRIVACY PRACTICES

As a provider of Mental Health services, Chitter Chatter is required to protect your privacy and provide you with this notice of the steps we take to assure that your personal health information is kept confidential.

This Notice describes your rights and our obligations regarding the use and disclosure of your health information. Over time we may revise this Notice however, if we do, we are required to inform you of our new privacy policy by making a revised Notice available to you. Copies of the Notice can be obtained in our office. All persons who receive services will be asked to sign or re-sign a "Consent for Treatment", which will serve as your acknowledgment of this Notice.

When you come to CHITTER CHATTER P.C. , a record of your treatment is started. This record contains "demographic information" (such as name, address, telephone number, social security number, birth date and health insurance information) as well as other information including why you have come to our program, how you say you feel, what health problems you have, treatments you may have received, observations by health care providers, diagnosis and plan of care. This information is known as Protected Health Information, or **PHI**, and is used for a number of purposes that are explained in more detail in this Notice. We do not sell your **PHI** and we take steps to protect your **PHI** from people who do not need or have the legal right to see it.

**TREATMENT, PAYMENT AND OPERATIONS**

We may use your **PHI** for treatment, payment purposes, or for agency operations making reasonable efforts to limit the use and disclosure of PHI to the minimum amount necessary to accomplish the intended purpose. This is covered when you sign the "Consent for Treatment" form at intake. All current service partners will sign a revised "Consent for Treatment" form upon receipt of this Notice. Your signed "Consent for Treatment" form will be your Authorization for the use and disclosure of your **PHI** for treatment, payment purposes, or for agency operations according to the following definitions.

Treatment: Your **PHI** will be used to provide, coordinate, or manage your care and related services. This includes the coordination or management of your treatment with another person like a doctor or therapist.

Payment: Your **PHI** will be used and disclosed to obtain payment for the services we have provided. This may include communications to your health insurer to obtain approval for treatment. or may include statistical reports to agencies making funds available to us for your benefit.

Operations: We may use your **PHI** within our agency in order to maintain or improve services. This can include quality assessment, accreditation, licensing or business management and general administrative activities.

Other uses and disclosures covered by your treatment, payment and operations Authorization include:

- Calls to remind you of an appointment and messages left on answering machines if you do not answer the telephone.
- To inform you of potential treatment options.
- To inform you of health benefits or services that may be of interest to you.
- To provide training to health professional students who are working in our agency.
- For research purposes if the study is approved by our Board of Directors and also meets the requirements of



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Federal and State law and regulation.

- To assist with or to avert a serious threat to the health and safety of you or the public.
- To report disease, injury, disability or death as required by law.
- To alert State or local authorities if we believe someone is a victim of child abuse, neglect or domestic violence.
- To alert authorities or medical personnel if we believe someone is at risk of injury by means of violence.
- To health oversight agencies for such purposes as audits, civil or administrative reviews, inspections and licensing activities.
- When required by federal, state or local law i.e. reporting laws, public health activities, national security, and intelligence activities.
- To a law enforcement official for law enforcement purposes such as responding to a court order, identifying a suspect or missing person, providing information about a crime victim or to report a criminal conduct.

At times, either Chitter Chatter or you may wish to use your **PHI** for a reason not identified above. In those cases, a special Authorization will be needed. If your **PHI** is requested for a use that requires a special Authorization, you will be told why your information is requested, who is asking for the information, and what information is requested. You will also be told how you may cancel your Authorization. If we have already acted on an Authorization you gave us earlier, your cancellation will affect information release for the future.

YOUR INFORMATION RIGHTS

In addition to the Authorizations already discussed, you have specific rights related to you Protected Health Information (**PHI**). These are:

- Right to Request Restriction of Uses and Disclosures: You may request limitations on the uses of your **PHI**. For example, you can ask that your information not be shared with certain family members. We are not always able to comply with these requests however, if we are unable or do not agree to your request, we will let you know. If we do agree to a restriction, and the restricted information is needed for your emergency care, we may still use or disclose the information as we think appropriate.
- Right to Request Alternate Methods of Communication: You may request an alternate method of receiving confidential mailings and other communications of your health information. For instance, you may request that your health information be sent to your office or to a post office box rather than to your home address. You may also request that calls be made to a certain telephone number. We do not require that you state a reason for your request.
- Right to Access **PHI**: You may request to review your **PHI** and obtain a copy. This request is made in writing to your counselor. If your request is accepted, we will arrange a mutually agreeable time for you to look at your health information. We may deny your request to review and copy in a few limited circumstances however, if your request is denied, you may ask for a review of that denial by contacting the Clinical Supervisor. A reasonable fee may be required for copies of health information. We will let you know what the fee will be before any copies are made.
- Right to Request an Amendment to Your **PHI:** You may request an Amendment to your health information if you think it is incorrect or incomplete. We will ask that the request be in writing and state the reasons for the amendment. We will notify you to let you know if we agree or disagree with your request. If we do not agree, we will provide you with information on why we disagree and what options you have. To request an amendment, please contact our privacy officers at the location where you receive services.
- Right to an Accounting of Disclosures of **PHI**. You have the right to request a periodic accounting of the disclosures of your health information so that you will be aware of who has had access to your information. Your request may specify a time period up to six years. We are not required to provide an accounting for disclosures prior to April 14, 2003 and not every disclosure included in an accounting. Disclosures you authorized in writing, routine internal disclosures such as those made to agency personnel in the course of providing you services, and/or disclosures made in connection with payment are all examples of things not



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included in the accounting. The accounting will state the time of the disclosure, the purpose for which it was disclosed and a description of the information disclosed. If there is any fee for the accounting, we will let you know what it is before the accounting is done.

- Right to Receive a Copy of this Notice: You will be offered a copy of this Notice during intake and additional copies will be available upon request at Chitter Chatter.



*Please initial: I have read and understand the contents on this page.* _____
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**COMPLAINTS**

If you have questions, would like additional information or feel that we have violated your privacy rights, you may contact our Office at 313-689-5188

Or by filing a written complaint with:

Wayne County:
DWMHA
707 W. Milwaukee Ave
Detroit, MI 48202-2943
Tel: (313) 344-9099
Tel: (313) 833-2500
TTY: (800) 630-1044

Monroe County:
Customer Services
1001 South Raisinville Road
Monroe, Michigan 48161
Tel: 734.243.7340
Tel: 800.886.7340
Fax: 734.243.5564

We will not retaliate against you or any person for filing a complaint or exercising your rights under the privacy regulations.

This notice is provided in accordance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996 effective April 14, 2003



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(please write in Physician's name and address, if possible)

_____ _____

_____

_____, _____ _____

Dear Dr. _____

Your patient _____ has begun to receive behavioral health services from our clinic.

In order to provide continuity of care, we wanted to let you know of this additional health care service your patient is involved in.

If you have any questions or concerns, please call our office.

Sincerely,

Chitter Chatter P.C. staff



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Chitter Chatter
Center for Therapy Services

**Intake information & Consent for Treatment Signature page- Please complete this form and the patient history form and bring to your first appointment**

**Last name:_____ First name:_____ Date: _____**

**DOB _____ Home Phone # _____ Cell # _____**

**E-mail _____ May we leave a message (circle) Yes No**

**Emergency Contact person: _____ Phone: _____**

**Primary Care physician name _____ Phone_____ City _____**

**How did you find out about us? _____**

**Certification of receipt and understanding of information packet**

I certify that I have read this packet and that I understand it and consent to it. Please initial each *underline* before a section in this packet that indicates that you read and understand that section:

_____ General Consent to Treatment

_____ Confidentiality

_____ Permission to video record (children's autism program only)

_____ Discharge Policy

_____ Autism services Attendance Policy and Video and public visitation observation consent

_____ HIPAA policy

_____ Payment Provisions

_____ I have completed a patient history form _____(therapist initials indicating completion)

_____ I am willing to allow Chitter Chatter . to send me information about new services or other announcements by e-mail. What is your preferred e-mail address? _____

_____ I agree to allow Chitter Chatter to inform my ____Primary Care Physician and/or ____ past Therapist that I am receiving services from this clinic (see attached letter). I agree that Chitter Chatter may contact them (after I complete a full release of information) regarding continuity of care issues. We will not provide any specific information about the type of services you receive unless you sign a specific release allowing us to do so.
I certify that I have read this packet and that I understand it and consent to it. If the signer is not the patient, the signer certifies that he is the patient's legally authorized representative, or, if a minor, his or her parent.

In consideration of the Facility and professional services provided or be provided to the patient, I guarantee payment of any Facility or physician charges which are not covered by or collected from any applicable health care benefit program, including deductibles and coinsurance amounts.



*Please initial: I have read and understand the contents on this page.* _____
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Signature of Patient or Legal representative or parent | Date

_____ _____

Witness | Date

_____ _____



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