**INTAKE SCREENING FORM**

**Instructions:**

Please complete and submit this screening form to schedule an appointment for an evaluation. You may submit this completed form to:

**E-mail: Info@Greatexpectationsaba.com**

**The following is a comprehensive list of what will need to be provided. Numbers 1-5 can be sent to BCBA via email before the initial meeting or given to BCBA in person. Numbers 6-7 can be addressed during the initial meeting.**

1. Your child’s most recent IEP/BIP
2. Records of therapy (previous and current) for your child.
3. Diagnostic Information
4. Insurance Cards (if applicable)
5. Any documents related to services being received such as past intervention reports, or other relevant documents.
6. Any special accommodation your child may use, such as a chewy, weighted blanket, communication devices.
7. BCBA/BCaBCA will have additional questions regarding :

-Specific items your child is reinforced by

-Developmental history

-Sleep schedule

-Communication skills

-Adaptive skills (potty training)

-Problem Behaviors

*Please answer to the best of your ability. If you do not know any answers, your Great Expectations ABA Supervisor will work with you closely to determine if it is relevant information necessary for treatment.*

**BIOGRAPHICAL**

**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s Social Security:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Subscriber ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caregiver/Legal Guardian #1**

*Name:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Parent’s Social Security:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Parent’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Telephone:*

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Email:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caregiver/Legal Guardian #1**

*Name:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Telephone:*

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Email:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICAL/SCHOOL INFORMATION**

* **Primary Care Physician:**
  + *(Name/Affiliation):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + *(Address):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + *(Phone Number):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **School Information:**

*(Name of School/Teacher)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + *(Address):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + *Phone Number):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + **Does your child have an active IEP**? **(YES / NO)**
  + **What grade level and placement setting does your child have at school? (i.e. EC Classroom, Gen. Education Setting, Resource)**
    - **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Service Providers (Speech/OT/etc.):**

***Please include Facility, Names of Providers, and Contact Information***

* + \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + **Autism Diagnostic Info:**
    - **Diagnosing Date (month/year):**
    - **Diagnosing Provider (name/credentials):**
    - **Facility of Diagnosis (Name/State):**
    - **Level of Diagnosis (i.e. 1, 2, or 3):**
  + **Any other Diagnoses (if none, please indicate):**
  + **BEHAVIOR:** Does your child have a history of **aggressive behavior** that can cause harm to self or others? If so, please provide a brief overview *(what it looks like, why it typically happens, and how often/how long the behavior can occur):*

**If you answered “Yes,” have there been any specific behavior interventions previously implemented for your child? (YES / NO / Not Applicable)**

* **What is your child’s main form of communication. Please circle all that may apply:** Verbally (with delays)**,** Verbally (age-appropriate)**,** Non-verbally (gestures only)**,** Communication Device**,** Picture Exchange (PECS)Other:
* **In regard to receiving ABA services, what are your main areas of concern you would like to see an increase/decrease in with your child?** 
  + ***Ex: Communication, Behavior, Independence Skills, Social Skills, etc.***
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Is there any other information important for Great Expectations ABA to be aware of in relation to your child that could impact ABA services?** **(YES / NO)**
  + **If you answered yes, please explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Self-Pay Itemized Agreement**

**ABA Service Agreement & Consent Form**

This document encompasses important information regarding Great Expectations ABA’s Applied Behavior Analysis (ABA) practice policies and professional services. It is necessary to thoroughly read through the following information (as well as information from the treatment plan) and ask for clarification at any time. Upon signing this agreement, you the consumer, will adhere to an agreement between you and Great Expectations ABA to provide ABA services.

**Payment Agreement**

The following payment agreement is outlined for the rendering of services for the client:

Services rendered will be for:

Financial Responsibility the parent/legal guardian is agreeing to:

* RBT/hr.: $50 \_\_\_\_\_
* BCaBA/hr.: $70 \_\_\_\_\_
* BCBA/hr.: $100 \_\_\_\_\_

This agreement is solely in relation to the above-mentioned services rendered for the above-mentioned client. If any further services or needs are required, an additional agreement will be warranted.

**Consent**

***By signing this agreement, I agree to pay the invoice provided upon receipt. I understand I am financially responsible for services rendered and if any additional services are needed, I understand a new agreement is required. By signing this agreement, I consent to the services offered for the intent and purposes outlined above.***

**Parent/Legal Guardian Signature Date**

**GEABA Admin Signature Date**

**ABA Service Agreement & Consent Form**

This document encompasses important information regarding Great Expectations ABA’s Applied Behavior Analysis (ABA) practice policies and professional services. It is necessary to thoroughly read through the following information (as well as information from the treatment plan) and ask for clarification at any time. Upon signing this agreement, you the consumer, will adhere to an agreement between you and Great Expectations ABA to provide ABA services.

**Services Offered**

Great Expectations abides by the Behavior Analyst Certification Board (BACB) Guidelines for Responsible Conduct

* Services will be based on development and implementation of a functional behavioral assessment and an ABA treatment plan. ABA services will be provided by a Board Certified Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst (BCaBA), Qualified Autism Service Practitioner (QASP-S), or a Registered Behavior Technician (RBT). The BCaBA and RBT will be supervised by a BCBA. BCaBA/QASP-S may supervise and oversee programs where an RBT implements the behavior-change procedures. Supervision involves bi-weekly face-to-face supervision typically consisting of 1 hour observations, as well as weekly remote supervision observations with each individual RBT working with the client. Depending upon your insurance policy, telehealth options may be available for supervision purposes.
* Great Expectations ABA provides ABA services based upon the client’s current level of individualized needs. The treatment plan will contain antecedent and consequence-based strategies that are skill-based, functionally-equivalent, and non-aversive.
* Behavioral Assessment/Treatment Plan results are available to the client and/or family. Treatment Plan goals are included in the client’s Skills Page where any targeted behaviors, daily session notes, or data collection is stored. Skills can be accessed via the website or iPad/Samsung Tablet app. A Skills account will be set up for the client and/or client’s family for review at their leisure.
* Great Expectations ABA abides by HIPPA and BACB Ethical Standards regarding confidentiality. The client’s information will never be shared with others aside from authorized personnel. This includes therapists working with the client and household parents/guardians. If enrolled in school, the school system will not have access to the client’s information without written consent. Even with written consent, it is up to the discretion of Great Expectations ABA what information can and will be released. Any information released will strictly be on a case-by-case basis.
* In addition to direct ABA services, treatment will also include training and ongoing consultation following the research-based principles of ABA as they pertain to the client’s treatment plan. Aside from family, consultation may occur with other educators and any other related services providers upon approval.
* Upon your request, Great Expectations ABA will collaborate with other service providers that offer evidence based therapies or techniques such as Speech, OT, educators. While you have the right to enroll your child in any program you deem appropriate, due our ethical guidelines, we cannot participate in services that do not have research and scientifically established methods supporting them. Collaborating with other professions is done at the benefit of your child. Suggestions of other providers for techniques or goals to be incorporated in ABA therapy will be taken into account by the BCBA but they reserve the right to refuse implementation if it is outside our scope of practice or is in opposition to the researched, scientifically based practices that we adhere to.

**Assessment, Participation, and Standard Treatment Procedures**

Parent/guardian participation is a **mandatory** expectation of delivery of services. Participation may involve team meetings, data collection, and more importantly, implementation and involvement in the implementation of recommended strategies. Specific level of involvement will be discussed/ agreed to at outset of service implementation. If there is lack of involvement, Great Expectations ABA reserves the right to reconsider the appropriateness of services. Consultations will involve progress monitoring, abrupt changes in behavior, major transitions, current level of service needed, and potential barriers in treatment to strive toward positive results. In order to achieve consistency across settings, generalization of skills, and increased likelihood of success, parent training will be a necessary component for your child’s progress and implementation of services. Parent meetings/training is recommended to occur at least monthly. A parent/guardian or designated adult (over the age of 18) is required to be present during all sessions.

Upon authorization by insurance, or written agreement in self-pay cases, an initial assessment will be scheduled. Great Expectations ABA strives to provide non-aversive care using an integrated treatment approach to create a positive learning experience for any individual. An initial assessment may include observations of clients in the potential treatment setting, interviews with family members, and a clinical assessment. During an assessment interview Great Expectations ABA also asks that our clients and/or families share information about an individual’s preferences, dislikes, and needs that may arise during a clinical assessment as well as to provide input into the treatment plan. Initial interviews may be conducted to make recommendations; however, clinical assessments must be conducted to determine an appropriate and effective course of action regarding treatment. Clinical assessments may include standardized assessments of language, daily living, and social skills as well as 1:1 interaction with the client. Depending upon the specific assessment procedures required (this is determined on an individualized standard), the assessment process (development of the initial treatment plan) may take a total of 10-15 hours, or possibly longer. Assessments may take upwards of two weeks to complete for submission to insurance. Insurance standards mandate that assessments/authorization requests occur every six months.

Upon completion of the assessments, clients and/or guardians will receive a copy to review prior to submission to insurance. Services will not begin until insurance approval is received or a self-pay agreement is in place. Once authorization is in place, Great Expectations ABA will assign staff, set a therapy schedule, and begin services. During ABA therapy, you may observe therapists using technology to collect data, write notes, provide instruction, and/or use as reinforcers. The content of therapy sessions will be individualized according to treatment needs. This may include structured table time, toy/ video game play, outside play, contrived and/or casual conversation activities, daily living skills instruction, etc. Therapy services will also include implementation of empirically validated behavior modification procedures. If at any time you have questions about the content/schedule of therapy, contact your assigned supervisor.

Services are implemented by paraprofessional staff and overseen by a Board Certified Behavior Analyst, Board Certified assistant Behavior Analyst, or Qualified Autism Services Professional Supervisor. Paraprofessional staff are required to be supervised on an ongoing basis. Supervision may occur in person or via HIPAA compliant telehealth platforms. Frequency of contact will be determined by client/staff needs and in accordance with certification board guidelines.

Staff changes may transpire throughout the duration of treatment for clients due to various reasons. However, any staff changes would only be considered and implemented with parent/caregiver collaboration and approval. Staff changes for both the supervising staff (BCBA, BCaBA) and direct care staff (RBT) may transpire from one/more of the following reasons:

* Clinical needs such as:
  + Generalizing skills
  + Increasing opportunities for social aspects
  + Providing new skill sets from fellow staff members
  + Ensuring treatment fidelity (e.g., multiple different staff are seeing the same skill deficits and/or provide consistent implementation of treatment programs)
* Personnel Changes
* Client re-location to another region
* Client changes in insurance coverage (this would dictate what would be covered by insurance)
* Insurance changes to policies and procedures covering ABA services
* Client needs (e.g., behavioral, skill deficits, age-range, etc.)

Assessments are typically conducted bi-yearly. An updated treatment plan will be provided per authorization or update period. Additional assessments include, but are not limited to:

* Evaluation of treatment progress
* Modification and additions of treatment goals
* Administration of standardized assessments:
  + ABAS, PDDBI, SRS, Vineland, etc.
* Development of FBA/BIP
  + If this doesn’t occur at the onset of services, your child’s supervisor will thoroughly go over and obtain written consent for development and any modifications that alter the implementation or outcome of the BIP.

**Evaluations**

Great Expectations ABA employees endure consistent evaluations. It is vital to receive parent input in relation to these evaluations so we can ensure to provide consistent, productive, and effective ABA services for you and your child(ren). We will be requesting parents to fill out yearly evaluations on their staff and/or completing the evaluations after the first 6 months of service (and yearly thereafter) in order to gauge your perception on quality of care. We know your time is valuable and we greatly appreciate your time and consideration helping us improve and maintain our quality of services Great Expectations ABA staff provides.

If at any time you feel as though your staff members are not providing high quality services, and you have addressed these matters with the supervisor of your child’s case, please contact Katie Scott, Clinical Director for any concerns. Your concerns will be held confidential, however, will be addressed in a timely and efficient manner. Contact information can be found in the Communication Section of this Contract.

**Appointments & Cancellation Policy**

Great Expectations ABA is committed to providing consistent and reliable services as scheduled and agreed upon by the client/family. Upon initial treatment, a preliminary set of hours/days for ABA services are discussed. Changes with this schedule will require notice. Regular attendance is key in seeing progress in your child’s therapy session. Please refer to our cancellation policy below:

* Sessions cancelled with at least 24 hrs. advanced notice will not be charged.
* Sessions cancelled with less than 24 hrs. due to contagious illness (fever, vomiting, diarrhea, pink eye, contagious rash, etc.) will not be charged.
  + If you, your child, or anyone else in the household is experiencing a temperature above 100.4, gastrointestinal distress, productive cough, or other potentially contagious symptom, contact your case supervisor to discuss appropriateness of service delivery that day.
* Sessions cancelled with less than 24 hrs. due to reasons other than contagious illness will result in a warning letter detailing our policies.
  + If another session is cancelled with less than 24 hrs notice within a 6 month period, you will be charged a $50 cancellation fee. This fee will be due immediately at the start of the next scheduled session.
* Multiple cancellations are a hindrance to your child’s progress and an inconvenience to the therapists.
  + More than 5 cancellations in a three-month period will result in being charged at the regular therapy rate ($40/hr. for therapist, $100/hr. for supervisor).
  + More than 3 sessions missed with less than 24 hr. notice in a two month period will result in immediate termination of the therapeutic contract.
* Scheduled family vacations/other scheduled periods of absence will not result in any charges; however, prior notice is required. Vacations that last more than two consecutive weeks may result in loss of your child’s therapy spot. Consult with your BCBA or the Executive Director to determine the course of action if you are taking a long break from services.
* Other emergency situations will not warrant any additional charges.

Families and therapists are encouraged to reschedule missed therapy sessions. In any case where an extended period of time must be missed, re-evaluation of the client may be required to best determine the subsequent plan of action.

***Families will receive an official warning letter if any of the abovementioned events occur. This letter will be delivered via USPS.***

**Communication**

Great Expectations ABA is committed to responding to any questions, comments, or concerns regarding ABA services in a timely manner. We strive to provide the best quality services to clients, which includes timely and professional communication. The clients will be provided with telephone numbers and email addresses of those individuals involved in direct treatment services and planning.

Great Expectations ABA does not offer on-call coverage for ABA services and programs on a 24-hour basis. Clients may contact their program supervisor Monday-Friday from 8:00-6:00 (or during your child’s scheduled therapy times).

Any concerns regarding your child’s schedule, therapy program or treatment team should be directed to the supervisor in charge. The supervisor will do his/her best to address the concerns which may include replacement of treatment team members. If concerns are not addressed by the supervisor if it is outside the scope of his/her role, please contact the Clinical Director, Marilyn Shanks with any issues or concerns.

Great Expectations ABA strives to provide the best services to our clients. We uphold our staff to the highest professional standards. Employees are expected to communicate with clients and caregivers with utmost respect. We also expect caregivers to interact with our staff respectfully and appropriately. This includes inappropriate conversations with staff, abusive language, physical altercations, etc. The therapeutic relationship between our staff, your child, and you is extremely important. Any concerns about the professional relationship between staff and caregivers will be addressed directly by your supervisor and a plan will be agreed upon. If issues continue to arise, Human Resources will contact you to discuss a plan moving forward. If there continues to be a concern or if the situation is severe enough to warrant, services will be immediately terminated and you will be provided with a list of alternative providers.

Great Expectations ABA employees are required to maintain professional boundaries with clients and their families. We will never solicit or accept testimonials regarding our services, allow personal or charitable fundraising, accept gifts, or post client information on websites, social media, or other photo sharing sites.

**Methods of Communication**

Great Expectations ABA uses email, text messages, and phone calls as diverse platforms of communication. Many documents will be delivered electronically and requested for signature via DocuSign. If you would prefer paper copies, please notify the Client Coordinator, Clinical Director, and/or Owner your preference of document delivery and processing. In the event paper copies are preferred, there may be delays in document delivery, insurance processing, and or scheduling for your child.

Your consent for document delivery and methods of communication can be found on the ***Consent for Electronic Delivery and Communication*** form. If at any time your preferred method of communication changes, please allow up to 10 business days for processing and paper delivery to reflect preferred modifications.

**Client Rights and Remedies:**

Clients/Guardians have the right:

* to be informed of all treatment procedures including risks and benefits
* to have input on treatment plans including goals, reinforcement, potential aversive protocols, etc. \*
* to request copies of medical files including treatment plans, progress charts, etc.
* to ask for staff changes \*\*
* to refuse treatment suggestions \*
* to terminate services without notice \*
* to consent to release of PHI to medical/educational professionals, other family members, or anyone else you deem essential to treatment fidelity and success

Grievance Procedure:

* Contact your case supervisor if you have concerns regarding your technician, treatment plan, or other concerns relating to your child’s programming.
  + The supervisor will meet with you to address your concerns and offer resolutions.
    - Resolutions may include more training for staff, change in provider, change in treatment plan, etc.
* If the supervisor is unable to resolve the issue or if the grievance is with the supervisor, contact the Clinical Director to discuss options for resolution.
* If your concern is serious enough to warrant outside intervention, the following entities can be contacted:
  + Behavioral Health Center of Excellence (BHCOE)- https://bhcoe.org/become-a-bhcoe/report-a-compliance-concern/
  + Behavior Analyst Certification Board (BACB)- <https://www.bacb.com/ethics/#ethics_reporting>

\*See Discharge/Termination agreement for more information

\*\* Great Expectations ABA cannot guarantee immediate availability of new staff

**Discharge/Termination of Services**

As the consumer, you reserve the right to ask for treatment team changes or withdraw from services at any time from these services. This agreement involves an understanding from you the consumer to follow through with treatment plan suggestions to maximize your child’s treatment progress. Failure to adhere to the treatment recommendations may contribute to potential discharge and/or transition of services. Furthermore, if disagreement regarding behavior change procedures and/or treatment plan goals occur, you the consumer will work with the supervisor to alter said goals. Justification and clarification for behavior change procedures will be thoroughly explained so you the consumer will understand reasoning for implementation. Upon agreement of plan/goals, failure to adhere to the plan will result in termination of treatment. Discharge may also occur if Great Expectations ABA is unable to meet your scheduling/ treatment needs due to staff availability.

**Reasons for discharge/termination:**

* Caregiver/client request
* Inadequate progress despite treatment fidelity over a substantial period of time(criteria will be discussed with supervisor prior to discharge)
* Complete outcome of service: Client's referred excesses and deficits have been addressed and remediated. All problem behaviors identified at entry of service have been addressed and are exhibited within typical ranges. This may also include age appropriate ranges of development on standardized testing in the areas of diagnostic criteria, cognition, language (basic speech and language as well as a pragmatic language), social problem solving, executive functioning, and adaptive skill functioning.
* Insurance cancellation or changes affecting authorization approval
* Failure to pay bill according to agreement
* Disagreement/failure to follow through with treatment plan as agreed
* Behaviors/challenges are determined to be outside the scope of our expertise
* Scheduling conflicts resulting in inadequate staff availability
* Abusive and/or inappropriate behavior/language towards staff
* Failure to provide a safe, effective learning environment
  + Unsanitary conditions
  + Parent/spouse conflict
  + Substance abuse
  + Household pets not contained
  + Siblings/outside individuals interfering with session times

Great Expectations ABA and its employees are considered mandated reporters. If there is suspicion of abuse or neglect, we are required by law to report the concerns to the appropriate authorities. If the circumstance is such that it places our staff in an inappropriate, uncomfortable or dangerous situation, services will be immediately terminated.

If services are terminated by Great Expectations ABA, you will be provided with a list of alternative providers.

**Company Trainings**

Great Expectations ABA strives to continuously strengthen our employee’s skills in order to provide the best quality services for our families. In order to make these accommodations, there will be annual trainings held for Great Expectations ABA employees that will inadvertently interfere with therapy sessions. We will ensure to provide ample notice so you can plan accordingly for therapy sessions missed.

Furthermore, upon signing this contract, you agree to allow fellow Great Expectations ABA employees and/or future employees to shadow your child during therapy sessions with your designated RBT(s) strictly for training purposes. These individuals are obligated to sign confidentiality agreements prior to entering any family(s) homes in order to maintain privacy. The individuals shadowing may/may not be someone intended to work with your child. Unless otherwise notified by the supervising BCBA/BCaBA, these individuals are solely gaining training experience. The supervising BCBA/BCaBA will notify you of any individuals planning to shadow during therapy sessions.

**Insurance and payment**

Great Expectations ABA is in network with several insurance companies. Upon approval for services, we will bill insurance directly for services rendered. This requires the

release of PHI for the purpose of billing. By agreeing to services covered by insurance,

you agree to the release of this information. The client is responsible for co-payments and or deductibles as assigned by the insurance. As part of our provider agreement and your contract with your insurer, Great Expectations ABA is legally required to collect copays. Copays can be collected at the time of services or billed at a later date. Failure to pay copays without an agreement in place, may result in loss of services. If you have a concern about ability to pay, contact Marilyn Shanks to discuss payment plan options. There are several grants available to assist with ABA copays. These include:

ACT Today and ACT Today for Military Families-

<http://www.act-today.org>

Autism Cares-

<https://autismcaresfoundation.org>

Ezra B Smith Foundation

<http://www.ebsmithfoundation.org>

Talk About Curing Autism Now

<https://tacanow.org/family-resources/autism-grants/>

United Healthcare Children’s Foundation

https://www.uhccf.org/apply.html

You can also refer to <http://www.autismsupportnetwork.com/resources/autism-grants-unitedstates> for access to a more complete list

If there are insurance payment issues, we will attempt to resolve any disputes with the insurance company. The client will be responsible for any discrepancy that cannot be resolved with the insurance company (i.e., paying for sessions if we go over the allowed amount, insurance denial despite approved authorization etc.).

***If your insurance policy changes, you are responsible for notifying the company as soon as possible in order to avoid any lapse in services. Failure to provide sufficient notice and documentation of policy changes, may result in additional charges for services rendered, as well as a suspension of services until new insurance approval is granted. If a suspension in services occurs, we will not be able to guarantee your child(s) therapy schedule will be reserved.***

If we are not billing insurance then out-of-pocket cost for services will be **$50** per hour for RBT therapy time, **$70** per hour for BCaBA/QASP-S services, and **$115** per hour for BCBA services. An initial assessment will cost **$500**.

GEABA has the option for a professional Consult to determine if ABA services are beneficial for your child(ren) prior to the onset of formal services. The cost of this is **$450**. This can be broken down into 4-easy payments of $112.50.

**For Co-Pay:**

***Your Co-Pay amount will be determined based upon your specific insurance policy. You will receive a co-pay through Square or PayPal on a monthly basis. You will be notified of your specific responsibilities for rendered services.***

If you have agreed to contract for self-pay: We have agreed to:

**RBT Hours/Week:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BCBA/BCaBA/QASP-S Supervision Hours/Month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*For out-of-pocket services, you have the right to alter the hours for RBT/Supervisor at any time upon discussion with your Supervisor. Any changes will warrant a new contract.*

**Consent for Services:**

I am consenting to services from Great Expectations ABA for the following:

**\_\_\_\_\_ Consent to receive ABA services to include the intake assessment and subsequent 1:1 services**

**\_\_\_\_\_ Consent to receive Consultative Services only**

**Informed Consent**

Your signature below indicates you have received and read the information in this document. Consent by all parents/legal guardians is required for implementation of ABA services. By signing this agreement, you consent to receiving ABA treatment in the manner in which it’s described above.

These policies have been fully explained to me and I have had all questions answered in relation to the information provided in this document. I also understand I have the right to withdraw my consent at any time.

I fully and freely give my consent for services to be implemented as proposed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian Date

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Great Expectations ABA Representative Date

*This contract will be updated yearly. Due to these circumstances, a new contract will require signature on a yearly basis, or as changes arise.*

***Cancellation Policy/No Show Policy Appointments***

1. ***Cancellation/ No Show Policy for Appointment***

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.

1. ***Scheduled Appointments***

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

***3.Account balances***

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

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Print Name Patient Signature Patient/Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date

Patient Account #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Office Use Only)