Client Last Name: ________________________________

Intake Packet

2020-2021

Caprock Behavioral Solutions, LLC | *(806) 317-1071* | reception@caprockbehavior.com

Revised 9/4/2020

Enrollment Requirements:

1. Consultation
2. Completed Intake Packet & Registration Fee
    a. Pick Up Authorization
    b. Service Agreement and Consent Form
    c. Permission to Videotape and Photograph (Optional)
    d. Copy of Insurance Card & Picture ID of Subscriber
    e. Prescription for ABA Therapy
    f. Proof of Diagnosis
3. Enrollment Meeting
    a. Service Agreement and Consent Forms
    b. Financial Responsibility
    c. Attendance Policy
    d. Parent Guidelines
4. Assessment

Student Pick-up Authorization Form

I, ______________________________________ (parent/legal guardian) hereby give my authorization and consent for the following individuals to pick up my child, _____________________________, from Caprock Behavioral Solutions.

Name	Relationship	Pick Up (Y/N)	HIPAA Disclosure
______________________	__________	______	_______________________

HIPAA Disclosure:
Full: This person has access and is authorized to all Protected Health Information (PHI), including the ability to request changes to other individuals' ability to access PHI.
Receive: This person can receive detailed information about your child and their progress and programs but cannot make any decisions regarding your child's treatment.
Restricted: This person can only receive generalized information and will not receive any specific programming or progress information.
Closed: This person will not receive any information regarding your child.

It is our policy to request photo identification for anyone unfamiliar to us. ***Please inform the person on your pick-up list that if they do not have proper identification, we cannot release your child to them. All persons picking up must be 18 or older. The Lubbock Autism Academy retains the right to refuse release of child to anyone on this list due to suspicion of child harm, impairment of the individual picking up, relationship of individual to Caprock, or other reasons at Caprock's discretion.***

Parent Signature _______________ Date _______________

SERVICE AGREEMENT AND CONSENT FORM

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and student rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operation. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) attached to this Agreement, explains HIPAA and its application to your personal health

information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

SERVICES OFFERED

We will provide services specifically designed to help you (and/or your minor child), obtain the skills to integrate into a more social and productive lifestyle. Our full-time clinical program is designed for the individual client in a primarily one-on-one manner that requires intensive training, planning, and coordination to be successful. Goal-setting is conducted yearly at a minimum with updates and revisions occurring monthly. Reintegration into the public-school system is often a consistent goal for most families, and Caprock will provide assistance to school programs in the form of data collected, teaching stylization, behavior support, and successful reinforcements when requested by the families and the school district (with proper release of information request forms completed).

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

Services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions and as mandated by Texas and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

TO PROTECT THE STUDENT OR OTHERS FROM HARM

If we have reason to suspect that a minor or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a student is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, and intended victim, a minor’s parents, or others who could provide protection, or seeking appropriate clinicization.

PATIENT RIGHTS

Protected Health Information

Federal and state law mandates that all healthcare clinics protect and maintain the privacy of you and your child's health information, otherwise known as PHI. The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

Who Will Follow This Notice

This Notice describes the information privacy practices followed by our clinic employees.

The practices described in this Notice is followed by health care providers, who are members of our staff.

Clinic employees must follow this Notice with respect to:

- **How we use your PHI**
- **Disclosing your PHI to others**
- **Your privacy rights**
- **Our privacy duties**
- **Clinic contacts for more information or, if necessary, a complaint**

Using or Disclosing Your PHI

For Treatment
During the course of your treatment, we use and disclose your PHI. This information is shared between Registered Behavior Technicians (RBT), Board Certified Behavior Analysts (BCBA), and Counselors we have as non-contracted personnel to provide continuous and medically necessary treatment.

For Payment

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

For Healthcare Operations
Your medical record and PHI could be used in periodic assessments by medical professionals about the clinic's quality of care. Or we might use the PHI from real patients in education sessions with students in study to become a BCBA or RBT. Other uses of your PHI may include business planning for our clinic or the resolution of a complaint.

Special Uses
Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

Your Authorization May Be Required
In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This consent will only be sought after when we require additional records from other medical professionals, or other medical professionals need this information from us. You have the right to end this consent at any time, limit what information is shared, and/or deny such requests.

Certain Uses and disclosures of your PHI required or permitted by law
As a clinic or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

Required or Permitted Uses and Disclosures

- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

We may also use or disclose your PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a workers compensation program.

- When properly requested by law enforcement officials, with proper court authorized requests.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For surveys, including patient satisfaction surveys.

Your Privacy Rights and How to Exercise Them

Under the federally required privacy program, patients have specific rights.

Your Right to Request Limited Use or Disclosure
You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

Your Right to Confidential Communication
You have the right to receive confidential communications of PHI from the clinic at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

Your Right to Revoke Your Authorization
You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

Your Right to Inspect and Copy
You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

Your Right to Amend Your PHI
If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

Your Right to Know Who Else Sees Your PHI
You have the right to request an accounting of certain disclosures we have made of your PHI over

the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and healthcare operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

Your Right to be Notified of a Breach
You have the right to be notified following a breach of unsecured PHI.

Your Right to Obtain a Paper Copy of This Notice
You have the right to obtain a paper copy of this Notice upon request, even if you have agreed to receive the Notice electronically.

What if I have a complaint?
If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at 1-800-852-3449. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C. 20201 or call 1-877-696-6775.

Contact for additional information
If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

Some of Our Privacy Obligations and How We Fulfill Them

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this Notice. We are required to abide by the terms of the Notice currently in effect. However, we reserve the right to change this Notice and our privacy practices when permitted or as required by law. If we change our Notice of Privacy Practices, we will provide you with a copy to take with you upon request and we will post the new notice.

Compliance with Certain State Laws
When we use or disclose your PHI as described in this Notice, or when you exercise certain of your rights set forth in this Notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our clinic. When state laws are not in conflict or if these laws do not

offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

CONSENT

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

____________________________ Student Name

____________________________ Date

____________________________ Parent/Guardian #1 Name

____________________________ Parent/Guardian #2 Name

____________________________ Parent/Guardian #1 Signature

____________________________ Parent/Guardian #2 Signature

PERMISSION TO PHOTOGRAPH, VIDEO, & RECORD

I give permission and consent for Caprock Behavioral Solutions, LLC to photograph, video, or audiotape my child and/or myself, and any other care giver, during the time my child is enrolled in services. I understand these medias may be used in staff trainings and/or for parent communication.

Child's name: __________________________________ Date: __________________

____________________________ Parent/Guardian Name

____________________________ Parent/Guardian Signature

Contact information

Name: ______________________________

Phone: ______________________________ H C W

Phone: ______________________________ H C W

Name: ______________________________

Phone: ______________________________ H C W

Phone: ______________________________ H C W

Intake Form

Background information:

Client's Name:

Date of Birth:

Parents' Names:

Insured under/Sponsors name:

Subscriber Date of Birth:

Subscriber's Address:

Insurance Type:

Policy number/Sponsors ID:

Secondary Insurance:

Insured under/Sponsors name:

Subscriber Date of Birth:

Subscriber's Address:

Insurance Type:

Policy number/Sponsors ID:

What is the best phone number to reach you:

What is the best email to reach you:

Medical Information:

Please give us a short synopsis of your child's birth and early developmental history:

Please list any diagnoses your child has:

Diagnosing provider:

Age of diagnosis:

What measures were used to diagnosis:

Primary Care Practice:

Primary Care Physician:

Does your child have any allergies or medical conditions:

Does your child have any dietary restrictions:

Please list any medications, length of time on medication, reason for medication:

Is your child currently receiving any other services (Speech, Occupational Therapy) and how often?

Have you ever received ABA services before and if so, please describe how long your child has received services?

Education:

For young children who are not yet school age:

Has your child attended any type of structured day-care or pre-school setting? If so, please describe:

For school age children:

What type of school does your child attend? (public, private, homeschool)

Does your child receive special education services? If so, please describe:

What are your child's academic strengths and weaknesses?

Current Skill Level:

Communication:

What is your child's main form of communication? (e.g. communication device)

How many words does your child typically use to request?

Does your child have 100 or more words they can use?

Does your child talk about items that are not present?

Please provide any other information you would like us to know about your child's communication.

Social skills:

Does your child independently interact with peers?

Describe your child's current social strengths:

Describe your child's current social weaknesses:

Please provide any other information you would like us to know about your child's social skills.

Self-Help Skills:

Is your child able to dress themselves without help?

Is your child able to bathe or shower independently?

Does your child have any issues with sleep?

Does your child have any issues with meal time or food variety?

Please provide any other information you would like us to know about your child's self-help skills.

Is your child toilet trained?

Problem Behaviors:

What events typically trigger problem behaviors (some examples may be asking them to complete a task, telling them they cannot have a toy or activity, or periods of low attention when they need to entertain themselves)?

What do the behaviors typically look like (some examples may be crying, laying on the floor, hitting, kicking, yelling, throwing items, head banging)

How long do these behaviors typically last?

How many times per week does your child typically engage in problem behaviors?

Does your child engage in any self-injurious behaviors?

Preferred items/Reinforcers:

Please list any items that your child enjoys or is passionate about.

What skills or behaviors are most important to you and your family to target during services?

1.

2.

3.

Policy: Financial Hardship

Policy

The following is an established set of guidelines for working with clients that declare a financial hardship.

Purpose

This policy is intended to establish criteria to determine the appropriateness of reducing co-pays, co-insurance, and/or deductibles based upon information received on a client's ability to pay.

Procedures

Under all circumstances, full amounts of co-pays, co-insurance, and deductibles shall be billed to each client. If it is determined that a financial hardship exists, Caprock shall reduce amounts based upon the charts that follow. Under NO circumstances shall Caprock reduce or waive co-pays, co-insurance, and deductibles in circumstances when clients cannot provide factual documentation of financial need, advertise the usage of financial hardship guidelines and policies, establish routines in granting financial hardships waivers, bill insurance providers or clients differently than any other client, fail to collect co-pays, co-insurance, and deductibles from any group unless they meet the financial hardship guidelines that follow, agree to any situation that accepts insurance payments as the sole source oy payment, or fail to reasonably collect a patient's balance.
Caprock reserves the right to modify or end reduced fee or waiver agreements at any time and without explanation.
Each hardship request is determined on a case by case basis.

Requirements

Each request for assistance with a financial hardship must request assistance in writing, provide the most current tax return, provide copies of the last 3 pay stubs from all financially responsible members of the household and any further information that may determine eligibility. This information may include birth of a child in the household, onset of disability to a member of the household, loss of financial resources, etc.
The client must receive more than 22 hours of therapy to be eligible

Caprock Behavioral Solutions
Lubbock Autism Academy
6104 66th Suite 100
Lubbock, Texas
(806) 317-1071

HEALTH & ILLNESS POLICY

Medication: All prescription medication must be prescribed by a doctor specifically for your child. All medication must be in its original un-expired container. All medication must be accompanied by a written schedule of when and how much medication to give your child. Only designated staff will dispense medication when the "Authorization to Administer Prescription and Non-Prescription Medication" form is completed by parent or guardian.

Antibiotics: A child with a contagious condition for which antibiotics have been prescribed may NOT attend school if he/she shows signs of illnesses as outlined below. This policy is for the benefit and protection of all children and staff.

Diarrhea: A child with diarrhea must stay (or go) home until the diarrhea has stopped for 24 hours and normal bowel movements have resumed.

Fever: When a child has a fever at 100° or higher, he/ she must stay home until the child has been fever-free and medication free for 24 hours. If a fever develops during the day, we will call you and you MUST pick up your child as soon as possible.

Head Lice: A child with head lice must stay home until specific treatment is completed and live lice and nits/eggs in hair and clothing are absent.

Impetigo and Conjunctivitis (Pink Eye): These are very contagious conditions and must be treated with antibiotics before the child may attend. If your child has red, runny eyes or scabby sores, you will be notified. Your child MUST be taken out of school until he / she has been seen by a doctor and been on medication for AT LEAST 24 hours.

Runny Nose: Generally, a clear discharge is okay, and a thick yellow-greenish discharge is a sign of a more serious infection. This is more dangerous for younger, rather than older children, and we will use our discretion about asking you to keep your child at home.

Strep Throat: A child with strep throat must not attend until he / she has been on antibiotics for 24 hours and is symptom-free and feeling well.

Vomiting: A vomiting child MUST go home if he / she becomes ill. He /She cannot return until vomiting has stopped for at least 24 hours.
If you take your child to a doctor because of an illness and your child needs to be out for three days or more, please bring a note from the physician stating that your child can return to school and on what date. It is very important to follow these policies, as they reflect a common respect and responsibility to protect the children from illnesses. Please sign below stating that you have read and understand Caprock Behavioral Solutions Health & Illness Policy.

Parent's Signature: ___________________________ Date:___________

Authorization to Administer Prescription & Non-Prescription Medication

I authorize Caprock Behavioral Solutions to administer the following medication (if applicable) Child's Name ___________________________________

Name of medication ______________________________

Amount to be given_______________________________

Times to be given ________________________________ (parent MUST give first dose)

Duration of date authorization ends _____________________________

Special instructions for administering ____