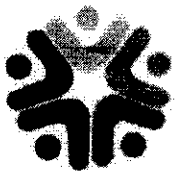


Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321.345.4232 • info@thepiecefits.com

Therapeutic Services Intake Packet

Thank you for your interest in Kaleidoscope Intervention's Services. This packet includes:

- ✓ Therapy Program Information
- ✓ Therapeutic Services Registration
- ✓ Client Behavior Inventory
- ✓ Service Availability Form
- ✓ Consent for videoing
- ✓ HIPPA Service Agreement and Consent Form
- ✓ Client Confidentiality Contact Form
- ✓ Limits of Confidentiality
- ✓ Request/Authorization to Release Confidential Medical Records and Information
- ✓ Informed Consent Form
- ✓ Client Financial Responsibility Agreement
- ✓ Credit Card Agreement
- ✓ Credit Card Evaluation Agreement

In order to receive services, Kaleidoscope Interventions will also require a copy of the following:

- ✓ Evaluation or Report Confirming Autism Spectrum Disorder Diagnosis
- ✓ Copy of Driver's License
- ✓ Copy of Insurance Card & ID (if military)
- ✓ Copy of IEP or Recent Evaluations

Website
www.ThePieceFits.com

Phone
(321) 345-4232

Mailing Address
1855 W. Hibiscus Blvd
Melbourne, FL 32901
E-mail
info@ThePieceFits.com

_____ Initials

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Applied Behavior Analysis (ABA) Services Information

What is ABA?

Applied Behavior Analysis (ABA) is an evidence-based approach to creating meaningful or socially significant behavior change. New skills and behaviors are taught while any problem behaviors are minimized. ABA focuses on behaviors that are observable and measurable, with respect to their antecedents and consequences, which are events that occur directly before and after the behavior of interest. This approach utilizes principles of reinforcement, which typically involves providing rewards to increase skills that are functional and socially significant throughout the child's daily life. ABA not only teaches these skills, but also promotes maintenance and generalization of the skills. Maintenance is used to determine whether or not the child can still perform the skill after a given amount of time has passed. Generalization requires that the child not only learns a particular skill in a structured 1:1 teaching environment, but ensures that the skill transfers to different people, materials, instructions, and environments. ABA also serves to decrease behaviors that may interfere with learning, such as tantrums, aggression, or stereotypy (hand flapping, spinning, etc.). Individualized curricula are developed to facilitate learning and develop appropriate programming for each child. Areas that we work on include (but are not limited to):

- *Language and Functional Communication:* Communicating needs/wants to others
- *Independent Play:* Playing without assistance
- *Social Skills:* Interacting with others
- *Imitation:* Imitating behaviors or vocalizations of others
- *Gross/Fine Motor Skills:* Control over balance and body movement
- *Listener Responding:* Attending and responding to spoken words
- *Visual/Perceptual Skills:* Interpreting things he/she sees visually
- *Self-help Skills:* Skills such as dressing, grooming, feeding, toilet training

Types of Services Kaleidoscope Interventions Provides

Center-based 1:1 Programming

Kaleidoscope Interventions provides a center-based program in which basic skills are taught to each child to enhance learning. Each child has 1:1 sessions with an ABA Specialist based upon his or her individual programming created by the BCBA. Once the child masters the prerequisite skills in the center-based environment, these skills will be tested for generalization in the home and community environment.

_____Parent Initials

Functional Behavior Assessment (FBA) and Treatment

This is designed for children who may have behaviors that are interfering with their ability to learn and participate in the community. An analysis of the behavior of concern will be completed via parent interview and direct observation. Once the analysis is conducted, a plan will be written in which parents receive recommendations for services and parent training. Training of the plan includes modeling of the behavior plan and observation of implementation of the plan with direct feedback for learning purposes.

Parent Training

All ABA services include a component of parent training. In order for therapy to have lasting effects, parents must assist the child with bringing the skills he or she learns in therapy to other natural environments, especially in the home and community settings. This may include making changes to the physical environment, changing the way family members interact with the child, and practicing and rewarding skills learned during therapy. Parents of children receiving services will participate in parent education and training related to their child's individualized programming. Participation by parents and significant family members is not only encouraged but expected for any program to be successful. We will host one parent training session a month at our clinic location. We strongly urge our families to attend at least 6 out of 12 parent education trainings.

Teaching Methodologies

Our program is comprised of a variety of teaching methodologies within the field of ABA to enhance the teaching of skills and decreasing problem behavior. The methodology used will be determined by how the child best learns. Methodologies include, but are not limited to, Discrete Trial Teaching (DTT), Incidental Teaching, and Pivotal Response Treatment (PRT). DTT allows us to break the skill down into very small units of learning and provide repetition to increase correct responding and ensure success. DTT is very common in "traditional" ABA approaches to learning. Incidental Teaching allows us to capture and contrive opportunities to learn throughout the day. For example, putting cookies on a shelf where the child cannot reach provides an opportunity to teach the child to request cookies. PRT involves teaching the child "pivotal" behaviors that create opportunities for the child to learn other more complex behaviors. The Verbal Behavior Approach is also utilized throughout each child's program to increase functional communication, whether it is vocally or through the Picture Exchange Communication System (PECS).

Data-based Decision Making

ABA is a field in which data is important in making decisions with each targeted skill. It gives us an objective way to assess progress for each child. It allows us to identify what learning strategies are most effective and those that are not. We can readily track progress to determine

_____Parent Initials

rate of learning and when the team may need to make changes to a child's program. The BCBA will create periodic progress reports and update programming as necessary to best support the child.

Positive Reinforcement

Positive reinforcement is used throughout each child's program to increase appropriate behaviors. Rewards (not bribes) are given to the child when we observe these behaviors. This increases the child's motivation for learning, as they are more likely to respond correctly with higher motivation. Once the child has mastered a particular skill, we systematically decrease the number of rewards to foster generalization of the skill using natural reinforcement. Additionally, if there are any behavior problems, we teach the child appropriate replacement behaviors to get the specific want or need met instead of using the problem behaviors. These replacement behaviors are then increased through reinforcement and thereby reducing the problem behaviors.

Individualized Curriculum

Each program is individualized for each child's needs and level of learning. This is determined via parent interview and directly testing the child's skills using assessment tools. Assessment reports are generated by the BCBA to give an explanation of the child's current skill levels and create goals for increasing socially significant skills.

Generalization

Each program involves a generalization program to foster independence and ensure that learning is occurring in the natural environment. Once the child has learned a skill in a structured setting, the clinician ensures that the skill is generalizing to different people, materials, instructions, and environments. This may include parent participation in having the child practice skills and behaviors at home and in the community and taking data on the child's responding.

Kaleidoscope Interventions Clinical Team

Director of Therapeutic Services

ABA Therapy is a growing team of people expanding to meet the needs of children with Autism Spectrum Disorder and related disabilities. The Director of Therapeutic Services works closely with our Board Certified Behavior Analysts (BCBAs), Certified Assistant Behavior Analysts (BCaBAs), and Behavior Therapists (BTs) to ensure a quality service is being provided to all of our families.

_____Parent Initials

Board Certified Behavior Analyst (BCBA)

The BCBA conducts descriptive and systematic behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The BCBA designs and supervises behavior analytic interventions. The BCBA is able to effectively develop and implement appropriate assessment and intervention methods for use in unfamiliar situations and for a range of cases. The BCBA teaches others to carry out ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in behavior analysis. BCBAs supervise the work of Board Certified Assistant Behavior Analysts and others who implement behavior analytic interventions.

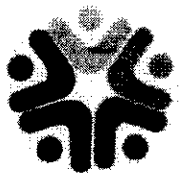
Board Certified Assistant Behavior Analyst (BCaBA)

The BCaBA conducts descriptive behavioral assessments and is able to interpret the results and design ethical and effective behavior analytic interventions for clients. The BCaBA designs and oversees interventions in familiar cases (e.g., similar to those encountered during their training) that are consistent with the dimensions of applied behavior analysis. The BCaBA obtains technical direction from a BCBA for unfamiliar situations. The BCaBA is able to teach others to carry out interventions and supervise behavioral technicians once the BCaBA has demonstrated competency with the procedures involved under the direct supervision of a BCBA. The BCaBA may assist a BCBA with the design and delivery of introductory level instruction in behavior analysis. It is mandatory that each BCaBA practice under the supervision of a BCBA.

Registered Behavior Technician

The Registered Behavior Therapist (RBT) is a paraprofessional who practices under the close, ongoing supervision of a BCBA or BCaBA. The RBT is primarily responsible for the direct implementation of skill-acquisition and behavior-reduction plans developed by the supervisor. The rBT may also collect data and conduct certain types of assessments (e.g., stimulus preference assessments). The RBT does not design intervention or assessment plans. It is the responsibility of the designated supervisor to determine which tasks a BT may perform as a function of his or her training, experience, and competence.

_____Parent Initials



Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Therapeutic Services Registration

Service(s) Requesting:

☐Applied Behavior Analysis ☐Speech Therapy ☐Occupational Therapy ☐Physical Therapy

Client Information

Client Name:_____ DOB: _____ SSN: _____
Mother/ Guardian Name:_____ Father/ Guardian Name: _____
Mother Primary Phone # _____ Mother Email Address _____
Mailing Address:_____ City:_____ State:_____ Zip: _____
Father Primary Phone # _____ Father Email Address_____
Mailing Address:_____ City:_____ State:_____ Zip: _____
Referral Source:_____

School Information

Is your child currently enrolled in public or private school? ____Yes ____No
If yes, please complete the following:
School Name: _____ County: _____
Grade: _____ Teacher Name: _____

Classroom Setting:

☐Self-contained classroom ☐ Resource room (partially mainstreamed) ☐Regular classroom
Other: _____

School therapies:
SLP: _____ X per week/month for _____; individual vs group
OT: _____ X per week/month for _____; individual vs group
PT: _____ X per week/month for _____; individual vs group
Other: _____

Medical History

Please list all medications you child is currently taking, including over the counter medications:

Medication	Dosage	Purpose	Date Started

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Allergy Information

Does your child have any known allergies to food or medications? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Physician Information

Primary Care Physician:_____ Phone: _____

Specialist:_____ Phone: _____

Specialist:_____ Phone: _____

Primary Insurance Information

Policy Holder Name: _____ Member ID: _____ Group # _____

Employer: _____ Insurance Company: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Information

Policy Holder Name: _____ Member ID: _____ Group # _____

Employer: _____ Insurance Company: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Step Up for Kids Information

Student Name: _____ PLSA ID Number: _____

McKay Scholarship Information

Student Name:_____ Grade:_____

Confirmation Number: _____-_____ District:_____

State Generated Funding: _____

Assignment of Benefits

I understand and agree that Kaleidoscope Interventions will file insurance claims or scholarship programs on my behalf for the services provided to the above named client and authorize payment of medical benefits, to include mental health benefits, to Kaleidoscope Interventions. I understand that I am financially responsible for all fees related to services to the participant above. I understand I will receive statements reflecting my account balances and that final payment for services rendered on this account are my responsibility.

Signature of Insured Party _____ Date_____

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Client Behavior Inventory

Behaviors of Concern

Please check how often the following behaviors occur. Some behaviors may not apply to your child or their age.

Screams/Tantrums	N/A	Never	Rarely	Sometimes	Frequently
Flaps arms	N/A	Never	Rarely	Sometimes	Frequently
Runs from you	N/A	Never	Rarely	Sometimes	Frequently
Hits or Bites others	N/A	Never	Rarely	Sometimes	Frequently
Interrupts others	N/A	Never	Rarely	Sometimes	Frequently
Difficulty pronouncing words	N/A	Never	Rarely	Sometimes	Frequently
Shy/Avoidant/Withdrawn	N/A	Never	Rarely	Sometimes	Frequently
Easily distracted	N/A	Never	Rarely	Sometimes	Frequently
Does not listen when spoken to	N/A	Never	Rarely	Sometimes	Frequently
Fidgety/Squirmy	N/A	Never	Rarely	Sometimes	Frequently
Difficulty remaining seated	N/A	Never	Rarely	Sometimes	Frequently
Runs around excessively	N/A	Never	Rarely	Sometimes	Frequently
Difficulty playing quietly	N/A	Never	Rarely	Sometimes	Frequently
Hyperactive	N/A	Never	Rarely	Sometimes	Frequently
Difficulty awaiting turn	N/A	Never	Rarely	Sometimes	Frequently
Difficulty organizing tasks	N/A	Never	Rarely	Sometimes	Frequently
Anxious/Nervous	N/A	Never	Rarely	Sometimes	Frequently
Sleep disturbances	N/A	Never	Rarely	Sometimes	Frequently
Doesn't pay attention to details	N/A	Never	Rarely	Sometimes	Frequently
Makes careless mistakes	N/A	Never	Rarely	Sometimes	Frequently
Does not complete work	N/A	Never	Rarely	Sometimes	Frequently
Refuses adult's requests	N/A	Never	Rarely	Sometimes	Frequently
Defiant	N/A	Never	Rarely	Sometimes	Frequently
Argues with adults	N/A	Never	Rarely	Sometimes	Frequently

Loses temper easily	N/A	Never	Rarely	Sometimes	Frequently
Blames others for own mistakes	N/A	Never	Rarely	Sometimes	Frequently
Deliberately annoys others	N/A	Never	Rarely	Sometimes	Frequently
Easily annoyed by others	N/A	Never	Rarely	Sometimes	Frequently
Bullies/teases others	N/A	Never	Rarely	Sometimes	Frequently
Is angry/resentful	N/A	Never	Rarely	Sometimes	Frequently
Steals from others	N/A	Never	Rarely	Sometimes	Frequently
Manipulates others	N/A	Never	Rarely	Sometimes	Frequently
Expelled from school	N/A	Never	Rarely	Sometimes	Frequently
Initiates fights	N/A	Never	Rarely	Sometimes	Frequently
Physically aggressive to others	N/A	Never	Rarely	Sometimes	Frequently
Physically aggressive to animals	N/A	Never	Rarely	Sometimes	Frequently
Uses weapons	N/A	Never	Rarely	Sometimes	Frequently
Violent with others	N/A	Never	Rarely	Sometimes	Frequently

Briefly describe how the child expresses the following emotions:

Happiness_____

Sadness_____

Anger_____

Anxiety_____

What behaviors would you like to see improved?

_____

_____

Is there any additional information we should know?

_____

_____

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Service Availability Form

Scheduling & Routines

To aid us in creating a therapy schedule for your child, please write out your typical weekly schedule and availability for services. Please include all of your availability for services and indicate what your preferred hours of service would be.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Are there certain activities you would like the therapist to join with your child? Yes No

Please describe the activity and time:

_____

_____

Please list any other accommodations:

_____

_____

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

CONSENT AND RELEASE TO PHOTOGRAPH/VIDEOTAPE STUDENT

(Circle one) **CONSENT** **DO NOT CONSENT**: to the photographing/videotaping of my child while he/she is involved in any school programs and/or activities during the present school year. I also consent to the release of my child's name, both verbally and in print, when used in connection with said photograph/videotape. It is understood that the photograph(s) and the name of my child may be used for promotional purpose inside and/or Puzzle Box Academy.

(Circle one) **CONSENT** **DO NOT CONSENT**: to the use of the above mentioned photograph(s) /videotape(s) and the name of my child for promotional purposes on the Internet.

I do herby release and waive any and all claims, demands or objections against Puzzle Box Academy in connection with or arising out of the said photograph /videotape of my child. It is understood that Puzzle Box Academy will not duplicate photograph(s)/videotape(s) for the use or benefit of any individual student or parent. It is also understood that failure to circle
Consent or Do Not Consent above will constitute parent/guardian consent for the purposes described above.

PARENT/GUARDIAN SIGNATURE: _____
Date:_____

PARENT/GUARDIAN (PRINT NAME): _____

Parent/Guardian verifies that the information provided is true and correct, and understands that Puzzle Box Academy
will rely upon this information as true and correct. Parent/Guardian acknowledges that there are legal penalties, including possible criminal penalties, for intentionally providing false information to Puzzle Box Academy.

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

HIPAA Services Agreement and Consent Form

THIS NOTICE DESCRIBES HOW THERAPEUTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Kaleidoscope Interventions (KI) may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- **PHI** – Refers to information in your health record that could identify you.
- **Treatment** - when a health care professional provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when a therapist consults with another health care provider such as your family physician or another therapist.
- **Payment** – when KI obtains reimbursement for your healthcare. Examples of payment are when KI discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- **Health Care Operations** – when KI discloses your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.
- **Use** – applies to activities within the KI office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **Disclosure** – applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.
- **Authorization** – means written permission for specific uses or disclosure.

II. Uses and Disclosures Requiring Authorization

KI may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when KI is asked for information for purposes outside of treatment and payment operations, KI will obtain an authorization from you before releasing this information. KI will also need to obtain an authorization before releasing your therapy notes. Therapy notes are notes your therapist has documented about each service provided. You may revoke all such authorizations (of PHI or Therapy Notes) at any time; however, the revocation or modification is not effective until received by KI in writing.

III. Uses and Disclosures with Neither Consent nor Authorization

KI may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If a therapist knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that they report such knowledge or suspicion to the Florida Department of Children and Family Services.

_____Parent Initials

- **Adult and Domestic Abuse:** If a therapist knows, or has reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, they are required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.
- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, KI may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

IV. Clients' Rights and Clinician's Duties

Clients Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, KI is not required to agree to a restriction you request.
- **Right to Received Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and alternative locations. For example, you may not want a family member to know you are in treatment. Upon request, KI will send your bills to another address.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in KI's behavioral health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, KI will discuss the details of the request process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. KI may deny your request. On your request, KI will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive and accounting of disclosures of PHI regarding you. On your request, KI will discuss with you the details of the accounting process.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from KI upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties

- KI is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI.
- KI reserves the right to change the privacy policies and practices described in this notices. Unless you are notified of such changes, however, clinicians are required to abide by the terms currently in effect.
- If KI revises the policies and procedures, they will make their best effort to contact you with this information via e-mail or in-person.

V. Complaints

If you have questions about this notice, disagree with a decision KI makes about access to your records, or have other concerns about your privacy rights, you may contact KI at 321-345-0861.

_____Parent Initials

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Acknowledgement of HIPAA Services and Consent Agreement

Client Name: _____ **Client DOB:** _____

The *Notices of Clinician's Policies and Practices to Protect the Privacy of Your Protected Health Information* (The Notice) describes how behavioral and medical information about you may be used and disclosed and how you can get access to this information. A printed copy of this notice is available to you as well in your intake paperwork and can be made available per your request.

By signing this form, you acknowledge the availability of The Notice. The Notice is subject to change. If the notice is changed, you may obtain a current copy by calling 321-345-4232. If you have any questions about The Notice, please contact Kaleidoscope Interventions.

I acknowledge the availability of the *Notices of Clinician's Policies and Practices to Protect the Privacy of Your Protected Health Information.* I may review the posted notice or request a copy of the notice from Kaleidoscope Interventions.

Guardian Signature: _____ Date: _____

_____Parent Initials

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Client Confidentiality Contact Form

Client confidentiality is a top priority at Kaleidoscope Interventions. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.

In the event that I, _____, am unable to be reached, Kaleidoscope Interventions may leave information with the following:

_____ Other Adult in Household (Name): _____
_____ On Home Answering Machine (#): _____
_____ On Cell Phone (#): _____
_____ I may be reached at my work number: _____
_____ May leave a message at work on my voice mail: _____
_____ Other (Please describe): _____

OPT OUT

(Initials) _____ In the event that I am unable to be reached, Kaleidoscope Interventions MAY NOT leave information with anyone but myself. I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff at Kaleidoscope Interventions.

Parents Signature: _____Date: _____

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Limits of Confidentiality

Client Name: _____ **Client DOB:** _____

The contents of a referral, intake, assessment, or treatment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and/or report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed.

_____Parent Initials

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Insurance

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

I have read, understand, and agree to the provisions of this Limits of Confidentiality Form:

Signature of Guardian_____ **Date:** _____

_____Parent Initials

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Request/Authorization to Retrieve Confidential Records and Information

1. I, _____, the parent/legal guardian of _____ (Child's name and date of birth), am completing this form to allow the use and sharing of my child's protected health information.

2. I authorize the behavior analysts and therapists with Kaleidoscope Interventions who are serving my family and child to share information regarding my child's treatment and service provision with the below noted individuals and/or organizations:
   List below the individuals and/or organizations with which you authorize the sharing of information. Please be sure to provide contact information and complete address for each individual or organization.

   a. Name: _____ Position: _____
      Organization: _____
      Address: _____
      Phone Number: _____ Fax Number: _____
   b. Name: _____ Position: _____
      Organization: _____
      Address: _____
      Phone Number: _____ Fax Number: _____
   c. Name: _____ Position: _____
      Organization: _____
      Address: _____
      Phone Number: _____ Fax Number: _____

3. I understand and agree that this authorization will be valid during the time my child is receiving treatment through Kaleidoscope Interventions or during the time span noted here: _____

4. I understand that I can revoke or cancel this authorization at any time by notifying the office. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that information may have been sent or shared before that date.

5. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my child's access to treatment through Kaleidoscope Interventions.

6. I understand that I may inspect and have a copy of the health information described in this authorization.

Parent/Guardian Signature: _____ Date: _____

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Informed Consent for Assessment and/or Clinical Treatment

I, _____, agree to have my child _____ evaluated/treated through Kaleidoscope Interventions. I understand that these services are based on an applied behavior analysis (ABA) model and will be provided by a professional trained in ABA.

I also understand that Kaleidoscope Interventions specializes in the evaluation and treatment of problem behaviors, and that if Kaleidoscope Interventions is unable to meet my particular needs, I will be referred to an appropriate agency or individual. If my child or I are here with a medical-related problem, my physician will be made aware of my treatment through Kaleidoscope Interventions and is responsible for medical aspects of my case (i.e., medication, physical examination, etc.)

Appointments
Appointments range in duration from 1-3 hours per session and are provided weekly, bi-weekly, monthly or as needed as determined by the clinical team. If you need to cancel or reschedule a session, we ask that you provide us with 24 hours' notice. If you miss more than 3 sessions without canceling, or cancel with less than 24 hour notice, you will be charged a cancellation fee of $25.00 for each following cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the entire fee as described above. If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. All scheduling must go through our main office.

Professional Fees
You are responsible for paying for services at the time of your session unless prior arrangements have been made. If you have insurance coverage, as a courtesy, KI will file claims on your behalf in accordance with our Financial Policy. Payment is accepted in the form of cash, check, or credit/debit card. Any checks returned to the office are subject to an additional fee of $25.00. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment.

Confidentiality
KI's policies about confidentiality, as well as other information about your privacy rights, are fully described in our HIPPA policies. You have been provided with a copy of that document and it is posted in our therapy offices. Please remember that you may ask questions at any time regarding our privacy policy.

Other Rights
If you are unhappy with your therapy services, we encourage you to speak with the Director of Operations so that they can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You are also welcome to contact the Director of Therapeutic Services anytime regarding your concerns. You may also request that we refer you to another

_____Parent Initials

therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about your therapist's specific training and experience.

Consent for Psychotherapy and/or Assessment

Your signature below indicates that you have read this Informed Consent for Behavioral Therapy and/or Assessment and agree to their terms.

Signature of Parent or Guardian: _____ Date: _____

_____Parent Initials

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Client Financial Responsibility Agreement

Client Name: _____ **Client DOB:** _____

Thank you for choosing Kaleidoscope Interventions (KI) as your mental health care provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our client financial policies.

Client Financial Responsibilities

- The client (or client's guardian, if a minor) is ultimately responsible for the payment for their treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the client is required to provide us with the most correct and updated information about their insurance, and will be responsible for and charges incurred if the information provided is not correct or updated.
- Clients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan or not deemed medically necessary by their insurance plan. Payment is due at the time of services. We accept payment in the form of cash, check, or credit/debit card.
- Clients may incur and are responsible for the payment of additional charges at the discretion of KI. These charges may include, but are not limited to:
    - NSF/Returned Check Fees. Returned checks will be processed and NSF fee assessed. ($25.00 per returned check)
    - Missed appointments without 24 hours advance notice ($25.00 per missed appointment)
    - Completion of extensive forms or reports ($25.00 per half hour) not included in therapy services
    - Any costs associated with collection of client balances

Client Authorizations

- By my signature below, I hereby authorize KI and the therapists, staff, and other health care professionals associated with KI to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care. I understand the health information I authorize to be released may include any of the following:
    - Records of Behavior Analysis Testing, results, diagnosis, and/or treatment.

- By my signature below, I hereby authorize assignment of financial benefits directly to KI and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below. I authorize KI personnel to communicate with me by mail, answering machine message, and/or email according to the information I have provided in my registration information.

I have read, understand, and agree to the provisions of this Client Financial Responsibility Form:

Signature of Parent or Guardian: _____ Date: _____

Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Credit Card Agreement

As required in the Services Agreement, in order to provide services to your child, parents/guardians are to provide a valid credit or debit card on file to allow Kaleidoscope Interventions to charge for your monthly balance or any other outstanding balance that becomes due.

Parents/guardians are responsible for notifying Kaleidoscope Interventions of any changes in their credit card status and are required to sign a new Credit Card Agreement at the time of such change. The charge shall occur automatically on the 15th AND 30th of each month (February will charge on the last day of the month) unless Kaleidoscope Interventions receives payment otherwise such as a check before the 30th. Any valid adjustments after the charge will be made in the following month.

Any declined charges shall be considered as non-payment. Any invoices that are not paid by the due date shall bear a late fee of $25.00. Kaleidoscope Interventions may suspend services if payment is delinquent by more than ten (10) days. All credit card transactions will include a 3% service fee (which is the total cost to the office by Visa/Mastercard).

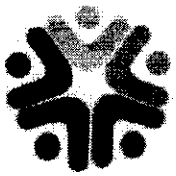
By signing below, I _____ give Kaleidoscope Interventions permission to charge my Credit Card the full amount of payment for therapy due on a bi-monthly basis.

This agreement will remain effective until all my outstanding balance is paid in full.

Name as it appears on card: _____
Credit Card Number: _____ Ex. Date _____
(Visa and Master Card only)
CVC code (3-digit code at the back of the card) _____

Billing Address: _____
_____

Signature _____ Date _____



Kaleidoscope
INTERVENTIONS

www.thepiecefits.com • 321-345-4232 • info@thepiecefits.com

Credit Card Evaluation Agreement

As required in the Services Agreement, in order to provide services to your child, parents/guardians are to provide a valid credit or debit card on file to allow Kaleidoscope Interventions to charge for your child's evaluation in the amount of $325.00.

Any declined charges shall be considered as non-payment. Any invoices that are not paid by the due date shall bear a late fee of $25.00. Kaleidoscope Interventions may suspend services if payment is delinquent by more than ten (10) days.

By signing below, I _____ give Kaleidoscope Interventions permission to charge my Credit Card the full amount of payment for therapeutic evaluation due on at the time of service.

Name as it appears on card: _____
Credit Card Number: _____ Ex. Date _____
(Visa and Master Card only)
CVC code (3-digit code at the back of the card) _____

Billing Address: _____
_____

Signature _____ Date _____