Concord Clinic

Dear Parent:

Thank you for your interest in obtaining services through Crotched Mountain's Ready Set Connect program. We are excited for you to join us! Enclosed is a questionnaire and record releases. If possible, please include a copy of your insurance card(s) when returning the forms.

It is extremely important that each one of these forms is filled out as completely as possible and mailed back to us before your appointment date; this includes personal and insurance information, as well as any required signatures.

If you have any questions or concerns, please call us at **603-224-7630.** Again, thank you for your interest. We look forward to receiving your intake information and meeting here with you at the clinic.

Ready Set Connect- Concord
57 Regional Drive, Suite 7
Concord, NH 03301

Checklist for First Visit

Please complete the following steps prior to your child's visit

Intake form

- *Contact and insurance information. Please fill out completely, sign and date.*

Releases

- *Complete "Authorization to Exchange Information" sign and date.*
- *Photo Release: sign and date*
- *Privacy Notice: sign and date*
- *Peanut Allergen Policy: sign and date*
- *Complete "Client Emergency Notification/Health Form"*
- *Parent Role in Treatment: sign and date*
- *Complete Credit Card Authorization (if applicable)*

Referral and other documentation

- *Insurance companies require a letter from your child's physician stating he/she has an autism diagnosis and ABA is medically necessary*
- *A diagnostic evaluation from your child's physician*

Insurance authorization

- *Is the service requested covered by your plan? Call your insurance carrier to find out. There may be co-pays or coinsurance you are responsible for.*

Insurance cards

- *Please bring all current insurance cards with you to the clinic*

Tips for a Great Ready Set Connect Experience

Attendance
In order for us to provide the very finest therapeutic experience for your child, we ask for families to ensure that attendance is regular. If you have to cancel a session, please let us know as soon as you can when you have a cancellation so we can adjust our schedule.

If attendance becomes an ongoing challenge, we will set up a meeting between you and your BCBA to discuss a plan that works going forward. Ready Set Connect serves many children and a dependable schedule is vital for our therapists to provide as much service to as many families as possible.

For cancellations, please contact your child's Site Director or Scheduler:

Margaret Maznek
Site Director
margaret.maznek@crotchedmountain.org
603-224-7630 option 1

Kali McKenna
Scheduler
kali.mckenna@crotchedmountain.org
603-224-7630 option 3

Parent Involvement
A central aspect of Ready Set Connect's approach is a close partnership with the child's family. As our goal is to help our children gain the skills that will translate into success outside of our clinic, we place immense value on an ongoing relationship with parents. We offer regular trainings and monthly clinic meetings with your child's BCBA, where you will get updates on progress as well as helpful tips and tactics that you can use at home. These opportunities for engagement are critical in your child's future success!

Don't Forget the Supplies!
Please remember to keep your child's backpack filled with all necessary daily supplies like diapers, wipes, a clean change of clothes, snacks, or any other items you may have discussed with your BCBA.

Ready Set Connect: **Contact and Insurance Information**

Personal contact information			***Guardian/Parent contact (1) (If applicable)***
Client's name			***Guardian/parent's name***
Date of birth (Month/Day/Year)	***M***	***F***	***Relationship to Client***
Street address			***Street address [if different from client's address]***
Street address 2			***Street address 2***
City/state/zip			***City/State/Zip***
Day telephone			***Day phone number***
Evening telephone			***Evening phone number***
E-mail address			***E-mail address***

Guardian/Parent contact (2) (If applicable)		
Second guardian name		***Relationship to client***
Street address [if different from above]		***Day phone number***
Street address 2		***E-mail***
City/state/zip		***Evening phone number***
Emergency contact information		
Emergency contact		***Relationship to client***
Day phone number	***Evening phone number***	***Cell phone number***

Referring sources ***Insurance authorization and billing procedures oblige us to send a copy of clinic reports to the primary care physician, or to the physician who referred you or your child for services. We endorse this practice, which facilitates continuity of care. Please indicate which physician should receive a copy of clinic reports.***					
Primary care physician name			***Other referring physician name***		
Street address			***Street address***		
City/state/zip			***City/state/zip***		
Phone number			***Phone number***		
Is this the physician who should receive a copy of the clinic reports?	***yes***	***no***	***Is this the physician who should receive a copy of the clinic reports?***	***yes***	***no***
Referring Diagnosis:					

Insurance company information					
Primary insurance company name			***Secondary insurance company name***		
Insurance company address			***Insurance company address***		
Insurance company phone number			***Insurance company phone number***		
Policy Holder's name			***Guarantor name (Person responsible for payment)***		
Policy Holder's birth date			***Guarantor birth date***		
Policy Holder's social security number			***Guarantor social security number***		
Policy Holder's employer's name			***Guarantor employer's name***		
Identification number:			*Identification number:*		
Prefix:	***Certificate number:***	***Suffix***	***Prefix***	***Certificate number***	***Suffix***
Group number			***Group number***		

Telephone message policy

We will leave messages at the telephone numbers listed unless otherwise indicated. All messages respect your confidentiality.

Payment information and policy

You have the option of paying for the clinic visit privately, or procuring payment through your insurance carrier (when applicable). Not all of the services offered by our clinic are covered by all insurance plans. It is your responsibility to assure that your plan covers the service that you have requested. We will be contacting your insurance carrier to verify your coverage.

Signature section.

Your signature is required for the reasons explained in the three paragraphs that follow. Please read these paragraphs, and sign on the line at the bottom if you agree to these conditions. Please do not hesitate to contact us with any questions or concerns you may have about this section.

1. ***Authorization of release of information***
   I authorize the Crotched Mountain ABA services to send a copy of any report to the primary care physician, and/or to the referring physician, as indicated on the reverse side of this page.
2. ***Authorization to be treated for assessment and treatment***
   I agree to be evaluated and treated, or to have my child/dependent for assessment and treatment, by an ABA Therapist. I understand that I can revoke this agreement at any time.
3. ***Assuring payment through your insurance plan***
   I hereby assign all medical benefits to which I am entitled and authorize and direct my insurance carrier(s) to issue payment of medical benefits directly to Crotched Mountain Rehabilitation Center for medical services rendered to my dependents or me. I hereby authorize the release of any medical information necessary to process insurance claims for medical services rendered to me or my dependents. I understand that I am responsible for all copays, coinsurances, non-covered services, cancellations, and appointments that are not honored by my insurance company or any other party. ***If an unpaid balance of $500 is accrued, services will be placed on hold until the balance is paid in full.***
4. ***In the event of an emergency*** *requiring hospital treatment, every effort will be made to contact parents (person* otherwise designated) before any action is taken. Please note that children will be taken to the closest hospital in the event of an emergency.
5. **Cancellation and No-Show Policy:** *Appointments must be canceled a minimum of 24 hours in advance. I understand if I fail to cancel an appointment without sufficient notice or if I fail to show up for a scheduled appointment, I will be charged $15.00 for the first occurrence, $20.00 for the second occurrence, and 25.00 for the third occurrence.*

Signed: _____ ***Date:*** _____

Ready Set Connect: General Medical Information for Children

The main concerns that I have about my child are:
1.
2.
3.

Concerns that other people (doctors, teachers, family members) have about my child are:
1.
2.
3.

PAST MEDICAL, DEVELOPMENTAL, OR MENTAL HEALTH DIAGNOSES:
List any diagnoses your child may already have, or diagnoses you think your child might have

Diagnosis	*When was diagnosis made?*	*Who made the diagnosis?*	*Do you agree with this diagnosis? (Circle one)*	*Comments*
			Y N Maybe	
			Y N Maybe	
			Y N Maybe	

MEDICATIONS ***List any medications taken by your child. Include dose and frequency if possible:***
1.
2.
3.
4.

ALLERGIES ***List any allergies your child may have***
1.
2.
3.

Ready Set Connect: Family History

Primary language spoken in the home:_____

Secondary language (if any): _____

Is this child adopted?……	***Y N***	*If yes, at what age?*
Is this a foster child?……	***Y N***	*If yes, for how long?*

Does anyone in the child's family have any of the following conditions? This section refers to biological family members (blood relatives)	
Diagnosis	***Which family member has this diagnosis?***
Learning disability	
Attention deficit disorder	
Autism or PDD	
Intellectual or Developmental Disorder	
Cerebral palsy	
Birth defect	
Epilepsy	
Chromosomal abnormality	
Vision impairment	
Other developmental disability	
Depression	
Psychosis	
Bipolar disorder	
Anxiety	
Any Chronic Infectious disease	

CHILD CARE		
Type of child care	***Number of hours per week***	***Number of other children at child care site***

Ready Set Connect: Educational and Therapeutic Services for Children

Early Intervention services	*# hours/ week*	*Comments*
Home visitor		
Center-based individual visit		
Child play group		
Parent support/information group		
Other (please describe)		

Therapeutic Services:	*# Hours/ week*	*Site of therapy*	*Comments*
Individual speech therapy			
Group speech therapy			
Occupational therapy			
Physical therapy			
Counseling or psychotherapy			
Social skills group			
Other therapies (please describe)			

School program	*#hours/week*	*Any comments or concerns?*
Regular education setting		
Resource room		
Special education setting		

School contact information
School name
School street address
City/State/zip
Phone number
Teacher's name
Name of other contact person who knows your child

Privacy Notice

Effective April 14, 2003

This document is available in an alternative format upon request.

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

Please read and return to Ready Set Connect - a signed copy of page 3.
Your signature is required before services can be initiated.

Ready Set Connect respects your right to privacy, especially related to your personal health information. To ensure your privacy, all employees, contracted providers, volunteers, and companies performing business functions for Ready Set Connect will treat personal and identifiable health information with the utmost confidentiality. Ready Set Connect is required by law to maintain the privacy of your health information, to follow the terms of this *Notice*, and to inform you of our legal duties and privacy practices with respect to your health information.

How Ready Set Connect May Use or Disclose Your Health Information

1. Ready Set Connect will need to utilize and release personal health information for treatment, payment and healthcare operations. **A) Treatment** - We will use your health information to provide the evaluation and consultation services you have requested. We may disclose your health information to Ready Set Connect therapists and other persons involved in providing or coordinating your services. **B) Payment** - We may use and disclose your health information so that your assistive technology services may be billed to, and payment may be collected from, you, an insurance company or a third party. **C) Healthcare Operations** - We may use and/or disclose health information in connection with our own quality assessment activities and for training and supervision of staff members.

2. We will share your protected health information with third party "business associates" performing various activities that are essential to the operations of our organization. The release of confidential information to business associates will occur only when necessary to provide the services you requested or to process essential functions such as billing, accounting, quality assurance, or legal and financial activities.

3. The staff of Ready Set Connect may use confidential information to provide you with appointment reminders or information related to treatment alternatives. Additional activities may include the assessment and design of program activities and/or to generate informational mailings. *A consumer may request to be removed from the Ready Set Connect mailing list by simply calling the privacy officer at 800.932.5837.*

4. We will disclose health information about you when required by federal, state or local law.

5. We may disclose health information relative to adverse events with respect to product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement

6. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

7. *We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and, in certain situations, in response to a subpoena, discovery request or other lawful process.*

8. *We may disclose health information for the following specific government functions: a) health information of military personnel, as required by military command authorities; b) health information of inmates, to a correctional institution or law enforcement official; and c) in response to a request from law enforcement, if certain conditions are satisfied.*

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described in this Notice. You may revoke this authorization, at any time, in writing, except to the extent that we have already relied upon your authorization in making a disclosure.

How We Will Protect Your Personal Health Information

1. Strict policies and procedures related to privacy will be followed when using computerized information, electronic mail, facsimile transmissions, voice mail as well as the storage of confidential records.

2. To protect personal health information from unauthorized or accidental release policies dictate the following:

    a. Your written consent or that of your legal representative (only) is required to release information to anyone not otherwise authorized by law to receive it.

    b. Requests for information related to mental illness, substance abuse, genetic testing results, HIV, or AIDS cannot and will not be released or re-released without a written consent from you or your legal representative.

    c. Our Business Associates, who receive protected health information, will be required to sign a Business Associates Agreement, which obligates them to follow procedures necessary to protect confidential identifiable health information and to use the information only for the stated purpose identified in the agreement.

Your Rights Regarding Your Health Information

1. You and/or your legal representatives may review the contents of your chart and obtain a copy (for a fee) after a written request is submitted. *All reviews of a consumer's chart will be conducted in the presence of a Ready Set Connect staff person.*

2. You are entitled to receive confidential communications of your protected health information by alternative means or at alternative locations. Please call the privacy officer to make such a request.

3. You and/or your legal representative may submit a written request to amend your protected health information to correct an inaccuracy or to improve clarity. All requests will be processed according to the organization's policies and procedures. Please note that Ready Set Connect is not obligated to agree to the requested amendment, but we are required to consider the request and inform you of our decision.

4. You and/or your legal representatives may obtain the disclosure history of your personal health information.

5. You and/or your legal representative may request, in writing, to restrict disclosures of personal health information, although Ready Set Connect is not obligated to agree to a requested restriction. We are however required to consider the request and inform you of our decision.

6. If you believe that your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Direct Complaints Regarding the Violation of Privacy Rights to:

Privacy Officer – Ready Set Connect

-or-
Secretary of the United States - Department of Health and Human Services

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This Notice was published and became effective April 14, 2003
Ready Set Connect reserves the right to amend this *Notice.*
All changes will be made known to you via a revised *Notice.*

Ready Set Connect

Use and Disclosure of Information

I certify that I have received a copy of the ***Privacy Notice,*** dated April 14, 2003

Consumer: _____ **Date**: _____

OR

Legal Representative: _____ **Date:** _____

TO ENSURE THE TIMELY DELIVERY OF SERVICES THIS PAGE SHOULD BE SIGNED AND RETURNED TO READY SET CONNECT AS SOON AS POSSIBLE

Physician Sample Letter for Insurance Authorization
PLEASE NOTE: THIS IS A SAMPLE ONLY. THE PHYSICIAN'S LETTER MUST BE WRITTEN ON THE PHYSICIAN'S OFFICIAL LETTERHEAD

To Whom It May Concern:

I am a pediatrician (_____) who has provided care to _____from 20____ to present. _____was diagnosed as autistic in early childhood. He/she currently meets the diagnostic criteria for autistic disorder 299.00. Specifically she shows (A.1) marked impairment in the use of nonverbal behaviors, (A.2) failure to develop peer relationships, (A.3) lack of spontaneous seeking to share interests, (A.4) lack of social or emotional reciprocity as well as, (B.1) delay in development of spoken language, (B.3) stereotyped and repetitive use of language, (B.4) lack of social imitative play, and (C.2) inflexible adherence to routines or rituals, and (C.3) stereotyped and repetitive motor mannerisms.

Applied Behavioral Analysis (ABA) is the best-established most evidence-based approach for the treatment of autism spectrum disorders. An intensive ABA program is medically necessary for the treatment of autism because its effectiveness has been clearly established through well-controlled scientific studies. Research has shown that ABA therapy helps to address the behaviors, speech/language/communication impairments, and social difficulties that children with autism spectrum disorders exhibit.

Therefore, intensive ABA therapy services are medically necessary for_____ to ameliorate _____'s condition of autism by improving his/her functional level.

Pick Up Authorization

Child's Name: _____

The following people are authorized to pick up my child:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Parent Signature: _____ Date: _____

*Your child will be released only to those persons listed on your authorization form. Please advise family and friends who occasionally pick-up that identification will be required. Please notify the office if there are any changes in pick-up plans or arrangements or changes on the authorization form.

Authorization to Exchange Information

Client's Name:_____

I request and authorize Ready Set Connect to exchange information with the personnel of:

Name: _____ Title/Relation:_____

Name: _____ Title/Relation:_____

Name: _____ Title/Relation:_____

Name: _____ Title/Relation:_____

Parent Signature: _____ Date:_____

*If you would like to authorize communication with specific individuals outside of Ready Set Connect, please list them above. (ex, your child's teacher, speech therapist etc.)

Nut Allergen Policy

Dear Parents and Guardians,

Multiple children at Ready Set Connect have severe food allergies to various kinds of nuts. We are asking your help to provide all children with a safe environment here at Ready Set Connect.

To reduce the chance of an allergic reaction, we ask that you do not send any nut products to Ready Set Connect in a snack or a lunch. If your child has eaten any form of nuts before coming to Ready Set Connect, please be sure that your child's hands and face are thoroughly washed before coming into the Clinic. It is important that there is strict avoidance of this food in order to prevent a life-threatening allergic reaction.

Thank you in advance for your cooperation! Please fill out the bottom section of this form and return it to Ready Set Connect with your child.

I have read and understand the nut free procedures for Ready Set Connect and I agree to do my part in keeping Ready Set Connect nut free.

Child's Name _____

Parent's Signature _____ Date _____

Ready Set Connect: Necessary Items

1.)Extra pairs of clothing - This includes:

- Pants
- Shirt(s)
- Underwear
- Socks

****Even if children are toilet trained we like to keep an extra pair of clothing in preparation of minor spills or messes from sensory activities! We ask that the clothing sent in is appropriate for the season and with labels on the tags with your child's name/initials.*

2.) Supply of bathroom materials – This includes:

- Extra underwear (if child is toilet training)
- Supply of pull ups/diapers for the day
- Package of wipes

****If you prefer to send in daily supplies of diapers and wipes just let us know and we will keep everything with the child's backpack.*

3.)Lunchbox with snacks and lunch (if applicable to schedule) with water bottle or sippy cup

****We kindly ask that labels are placed on your child's belongings (including lunchboxes and cups) since it is not uncommon for us to have duplicates! Reminder: RSC is a NUT-FREE facility!*

4.) AAC Device Accessories – Charging Cables

****If your child utilizes an AAC device, we ask that you send in any charging cables that may be used to ensure that we can utilize it during your child's session with us!*

Weather Cancellation Procedure at Ready Set Connect

Dear Parents and Guardians,

As the weather starts to change, we want to remind everyone of our snow and inclement weather policy. We want to ensure the safety of our families and staff at all times.

In the event of inclement weather, please look for cancellation or delayed opening on WMUR at wmur.com. When there is a change in the services at our Concord office, the website will list our clinic as 'Ready Set Connect Concord.'

Other Important Information:

- A 2-hour delay means the clinic will open at 11:00 a.m.
- On the WMUR website or app the notification appears with the "school" cancellations, but on the WMUR TV station the notification appears with the "business closures"
- If you need to **cancel** due to inclement weather, please call and leave a message as early as possible or email both the scheduler **kali.mckenna@crotchedmountain.org** and the Site Director **margaret.maznek@crotchedmountain.org.** This helps us to schedule therapists and children accordingly for the rest of the day.

If you have any questions do not hesitate to call the Concord office at **603-224-7630.**

Thank You,

Ready Set Connect

Ready Set Connect: Client Emergency Notification/Health Information

PARENT OR LEGAL GUARDIAN TO COMPLETE. Please help us to ensure that your child's health care needs are met by completing this form. This enables the school nurse to individualize a plan of care based on your child's specific needs and provides us with important emergency contact information.					
Student Name: Last		First		MI	
Student's Date of Birth	Sex ☐ Male ☐ Female		Student's Social security #		
Address		City:		State:	Zip Code:
Name of Mother or Legal Guardian	Home Phone:	Work Phone:	Cell Phone:	Employer:	
Name of Father or Legal Guardian	Home Phone:	Work Phone:	Cell Phone:	Employer:	
Name/Address of Pediatrician or Primary Care Provider				Phone #:	
Name/Address of Specialist Caring for your Child				Phone #	
In case of emergency – if parent/guardian cannot be reached – contact the following: Name _____ Relationship_____ Phone number(s) Home _____ Work _____ Other _____					
PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/legal guardian is responsible for providing the school with any medications, special food, or equipment that the student will require during the school day. Contact the school nurse to obtain specific forms for medication administration and/or procedures.					
PRIMARY DIAGNOSES (Please list all diagnoses for which student currently receives medical care)					
CURRENT MEDICATIONS (Please include doses, times they are given, and the reason for each)					

☐ **ALLERGIES**

Allergy type:

☐ Medication(s) (list medications)

☐ Foods (list foods)

☐ Insect stings (list insect(s))

☐ Others (list)

Reactions: (Date of last occurrence if yes)

☐ Coughing (Date: _____) ☐ Hives (Date: _____) ☐ Rash (Date: _____)
☐ Difficulty breathing (Date: _____) ☐ Local swelling (Date: _____) ☐ Wheezing (Date: _____)
☐ Generalized swelling (Date: _____) ☐ Nausea (Date: _____) ☐ Other (Date: _____)

Currently prescribed allergy medications/treatments:

☐ Oral antihistamine (Benadryl, etc.) ☐ Epi-Pen ☐ Other _____

☐ **ASTHMA**

Triggers: ☐ Environmental (i.e.smoke, dust, pets, pollen) Please list: _____

☐ Other _____

Symptoms:
☐ Chest tightness, discomfort, pain ☐ Difficulty breathing ☐ Coughing ☐ Wheezing ☐ Other _____

Currently prescribed asthma medications/treatments _____
_____

Does your child have a written Asthma Action Plan? ☐ Yes ☐ No

☐ **SEIZURE DISORDER**

Type of Seizure:
☐ Absence (staring, unresponsive) ☐ Complex partial ☐ Generalized tonic-Clonic (grand mal)
☐ Other (explain/describe)

OTHER HEALTH ISSUES (i.e. diabetes, gastrointestinal disorders, genetic syndrome)

SPECIAL PROCEDURES required (i.e. oxygen, bladder catheterization, tracheostomy care, suctioning)
☐ Yes ☐ No Explain:

BEHAVIORAL CONCERNS (Describe)

SPECIAL DIET REQUIREMENTS
☐ Yes ☐ No Explain:

VISION CONCERNS	**HEARING CONCERNS**
☐ None ☐ Contacts/glasses _____ ☐ Other	☐ None ☐ Hearing aid(s) ☐ Right ☐ Left ☐ Both ☐ Other

SPECIAL SAFETY CONSIDERATIONS (precautions for transfers, feeding, positioning, special safety equipment, etc.)
☐ Yes ☐ No Explain:

In the event of an emergency requiring hospital treatment, every effort will be made to contact parents (person otherwise designated) before any action is taken. Please note that students will be taken to the closest hospital in the event of an emergency.

Parent/Guardian Signature _____ Date _____

Part 3: To be completed by school nurse

I have reviewed this student's health information and initiated an individualized plan of care if indicated.
Notes:

_____

School Nurse Signature Date

Privacy Notice

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

Ready Set Connect respects your right to privacy, especially related to your personal health information. To ensure your privacy, all employees, contracted providers, volunteers, and companies performing business functions for Ready Set Connect will treat personal and identifiable health information with the utmost confidentiality. Ready Set Connect is required by law to maintain the privacy of your health information, to follow the terms of this *Notice* , and to inform you of our legal duties and privacy practices with respect to your health information.

How Ready Set Connect May Use or Disclose Your Health Information

1. Ready Set Connect will need to utilize and release personal health information for treatment, payment and healthcare operations. **A) Treatment** - We will use your health information to provide the evaluation and consultation services you have requested. We may disclose your health information to Ready Set Connect therapists and other persons involved in providing or coordinating your services. **B) Payment** - We may use and disclose your health information so that your assistive technology services may be billed to, and payment may be collected from you, an insurance company or a third party. **C) Healthcare Operations** - We may use and/or disclose health information in connection with our own quality assessment activities and for training and supervision of staff members.
2. We will share your protected health information with third party "business associates" performing various activities that are essential to the operations of our organization. The release of confidential information to business associates will occur only when necessary to provide the services you requested or to process essential functions such as billing, accounting, quality assurance, or legal and financial activities.
3. The staff of Ready Set Connect may use confidential information to provide you with appointment reminders or information related to treatment alternatives. Additional activities may include the assessment and design of program activities and/or to generate informational mailings. *A consumer may request to be removed from the Ready Set Connect mailing list by simply calling the privacy officer at 800.932.5837.*
4. We will disclose health information about you when required by federal, state or local law.
5. We may disclose health information relative to adverse events with respect to product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement
6. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
7. We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and, in certain situations, in response to a subpoena, discovery request or other lawful process.
8. We may disclose health information for the following specific government functions: a) health information of military personnel, as required by military command authorities; b) health information of inmates, to a correctional institution or law enforcement official; and c) in response to a request from law enforcement, if certain conditions are satisfied.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described in this Notice. You may revoke this authorization, at any time, in writing, except to the extent that we have already relied upon your authorization in making a disclosure.

IN-PERSON PARENT-FOCUSED ABA TRAINING

Parenting a child with Autism requires much support and a specialized set of skills. Since all families have unique needs and preferences, we have developed a variety of different formats for supporting parents with the skills to promote the successful development of their child.

Ready Set Connect is now offering the opportunity for parents to come to one of our centers and to meet with a BCBA, who will provide instruction on specific ABA skills and evidence-based practices and curriculum.

Everyone at Ready Set Connect is invested in supporting each child and helping them thrive in all settings of their life. Teaching skills that can only be demonstrated in a clinic setting with staff is not enough for us;. we want to see children generalize what they learn at Ready Set Connect and apply these skills at home and in the community.

To accomplish this, we want to establish a partnership between our BCBAs and the parents. Using parent input, Ready Set Connect staff will set goals for what the child can practice at home and what the parent can do to help. **With the help of our training, you and your child will meet these goals.**

We'll start small with whatever you can manage and then with our support you will find yourself teaching your child skills you may never thought possible!

Trainings will happen in each of our centers, scheduled at an agreed upon time between families and the BCBA. We will follow all necessary COVID-19 protocols. Please provide 24 hour notice by calling or emailing your child's center if you need to reschedule an appointment.

COVID protocols

- Limited to two outside family members
- Parents must participate in COVID health screening via phone 24 hours before training and at time of visit
- Masks are mandatory
- Social distance must be maintained
- Entrance through building at designated areas
- Parents will participate in follow up health screenings post visit and report any COVID related symptoms after the training to the Center Site Director.

Ready Set Connect
Parent's Role in Treatment

The importance of parents and guardians at RSC

Parents and guardians are critical members of the treatment team at Ready Set Connect. Their participation in the treatment process is one of the most important components of a successful outcome. Our staff's expertise in Applied Behavior Analysis is simply not enough to insure that your child receives the best possible treatment. We need your help to make sure your child gets the most out of their RSC experience. We completely understand that each family's needs and resources are different so we create a customized plan for every child and their parents/guardians. There are just a few simple things that we need your help

How can you assist with your child's treatment?

Parent - Focused ABA Training- Parenting a child with Autism requires a lot of support and a specialized set of skills. Since all families have unique needs and preferences, we have developed a variety of different formats for providing parents with the skills to promote the successful development of their child. Our clinicians utilize evidence based practices and curriculum to instruct parents in the specific skills that are required for their child. What we need is a commitment to participate in the scheduled sessions.

Set Goals for Home: Everyone involved in your child's treatment is invested in having them thrive in all settings of their life. Teaching your child skills that they can only demonstrate in our clinic or improving their behavior only with our staff is just not enough for us. We want them to "generalize" what they learn at Ready Set Connect to their home and community. To accomplish that, we will set some goals with you for what your child can practice when they are at home with you. We'll start small with whatever you can manage and then with our support you will find yourself teaching your child skills you may never have thought possible.

Provide us with Information: Data is the cornerstone of Applied Behavior Analysis. We make all of our treatment decisions based on our rigorous data collection. We also know that many parents want to know with some certainty how their child is progressing. It is very important for us as well to know how your child is doing at home. While we don't expect you to collect data on tablets like we do, we will ask you to provide us with some manageable information about your child's progress at home. The same as your child's pediatrician will want to know your child's temperature if they prescribe medication because of a fever, we'll want to know objectively how well they are behaving or performing a skill at home. Additionally it is always helpful when we are made aware of any life changes (e.g., an upcoming change in residence, someone moving in or out of the house, a family illness or traumatic event). We may be able to help your child adjust to these life events.

Attendance: Help us with your child's regular attendance. Our ABA therapists are scheduled such that your child will receive 1:1 treatment every minute they are scheduled at our clinic. Everyone has a different definition of "good" attendance. For us, 90% is the attendance standard that we seek to

maintain. While we know things can occasionally happen, if attendance drops below 90% for a period of time we will likely be in touch to determine what we can adjust to help it improve. Also, prompt drop off and pick up according to your child's schedule is very important for the effective delivery of our services. If your child is going to be absent, or an emergency requires you to be late either dropping off or picking up, we ask that you call us. If your child is more than 15 minutes late, we may need to cancel that session.

I have read and understand the expectations indicated above:

Parent/Guardian

Date

Credit Card Co-Payment/Missed Appointment Authorization

I, _____ authorize Ready Set Connect to charge my credit card with $ _____for my co-payment/ deductible/co-insurance/cancellation fee for every therapy session provided or cancelled less than 24 hours in advance to my child ,_____.

I understand that it is my responsibility to maintain sufficient funds and to notify RSC if there is a change to the credit card information on file.

Credit Card Information:

□ VISA □ MC □ AMEX □ DISCOVER

Account Number:

Expiration Date: (Month/Year)

Cardholder's Name: _____
Cardholder's Signature: _____

☐ **VERBAL AUTHORIZATION**