Client Name:

Date of Birth:

Member ID #:

READY SET CONNECT
POWERED BY GERSH AUTISM

Initial Intake Packet

Dear Parent,

Thank you for your interest in ABA (Applied Behavior Analysis) Therapy Services through our program at Ready Set Connect. We are excited to have you join us!

It is extremely important that each of these forms be completed and returned 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 1-888-319-7675.

We look forward to receiving your intake information and meeting with you at the Center.

Center Information

Ready Set Connect - Concord
57 Regional Drive, Suite 7
Concord, NH 03301
603-224-7630
Fax: 603-410-1105

Ready Set Connect - Tilton
580 Laconia Road
Tilton, NH 03276
603-527-8620
Fax: 603-410-1105

Ready Set Connect - Manchester
1750 Elm Street, Suite 112
Manchester NH 03104
603-792-0077
Fax: 603-410-1105

Admissions and Insurance Contact Information

Natalie Kitching-Rajak Insurance & Billing Manager Nkitching@readysetconnect.org 603-333-2880

Katherine Dunn Admissions & Billing Specialist Kdunn@readysetconnect.org 603-333-2888

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Initial Intake Packet Documentation

Required Clinical Documentation

Letter of Medical Necessity (LMN)

Please provide a Letter of Medical Necessity from your child's physician and a copy of the diagnostic evaluation completed by the provider who diagnosed your child with Autism Spectrum Disorder (ASD).

Insurance carriers typically require:

- A Letter of Medical Necessity stating that your child has been diagnosed with Autism Spectrum Disorder and that Applied Behavior Analysis (ABA) services are medically necessary.
- A copy of the comprehensive diagnostic evaluation completed by the diagnosing provider.

Required Intake Forms

Please complete, sign, and date each of the following forms:

- Intake Information Form
- Insurance Information Form
- Scheduling and Services Information Form
- Medical Information and Family History Form
- Request and Authorization for Pick-Up Form
- Request and Authorization to Exchange Information Form
- Policy and Consent Information Form

Required Acknowledgment Forms

Please review, complete, sign, and date the following acknowledgment forms:

- Parent Financial Responsibility and Insurance Coverage Acknowledgment
- Notice of Privacy Practices Acknowledgment
- Parent/Guardian Handbook Acknowledgment

Insurance Verification

Prior to the start of services, please contact your insurance carrier to verify coverage for ABA services.

Please note:

- Co-pays, deductibles, coinsurance, and other out-of-pocket expenses may apply.
- Verification of benefits does not guarantee payment by your insurance carrier.
- Families remain responsible for any patient financial responsibility determined by their insurance plan.

Please provide copies of all active insurance cards (front and back).

Sample Letter of Medical Necessity

Please Note: This sample is provided as a guide only. The physician's letter must be completed on official practice letterhead and signed by the child's diagnosing physician, developmental pediatrician, neurologist, psychiatrist, psychologist (if accepted by the insurance carrier), or primary care physician.

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Date

To Whom It May Concern:

I am Dr. _____, and I have provided medical care for _____ since _____.

The above-named child has been diagnosed with **Autism Spectrum Disorder (ICD-10 Code F84.0)** and continues to meet the diagnostic criteria for this condition.

The child demonstrates deficits and challenges that may include, but are not limited to:

- Impairments in social communication and social interaction
- Difficulty developing and maintaining peer relationships
- Limited social reciprocity
- Delays or deficits in expressive and/or receptive language
- Restricted, repetitive patterns of behavior, interests, or activities
- Difficulty with adaptive functioning and daily living skills
- Behavioral challenges that interfere with learning and social development

Applied Behavior Analysis (ABA) is a well-established, evidence-based treatment for individuals diagnosed with Autism Spectrum Disorder. Extensive scientific research supports ABA as an effective intervention for improving communication, social skills, adaptive functioning, and reducing behaviors that interfere with learning and development.

Based on the child's diagnosis and current level of functioning, ABA services are medically necessary to address deficits associated with Autism Spectrum Disorder and to improve the child's overall functional independence and quality of life.

Therefore, I recommend and support the provision of ABA therapy services for _____.

Sincerely,

_____

Physician Name and Credentials

_____

Signature

_____

Date

_____

Practice Name

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Intake Information Form

Personal Contact Information

Client's Name:	*Date of Birth:*
Address:	*Gender:*

Parent / Guardian Information (1)

Parent / Guardian Name:	*Relationship to Client:*	*Phone Number:*
Address:	*E-mail:*	

Parent / Guardian Information (2)

Parent / Guardian Name:	*Relationship to Client:*	*Phone Number:*
Address:	*E-mail:*	

Emergency Contact

Name:	*Relationship to Client:*	*Phone Number:*
Address:	*E-mail:*	

Referring Diagnosis

Diagnosis:

Referring Provider(s) Information

Provider Name:	*Provider Name:*

Location of Choice

☐ *Concord*	☐ *Manchester*	☐ *Tilton*

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Insurance Information Form

Primary Insurance Information

Insurance Company Name:		*Address:*	
Phone Number:		*Policy Holder's / Guarantor Name:*	
Policy Holder's Birth Date:		*Policy Holder's Social Security Number:*	
Policy Holder's Employer's Name:		*Annual Insurance Deductible:*	
Insurance Co pay:		*Max out of Pocket:*	
Prefix:	*Suffix:*	*ID #:*	*Group #:*

Secondary Insurance Information

Insurance Company Name:		*Address:*	
Phone Number:		*Policy Holder's / Guarantor Name:*	
Policy Holder's Birth Date:		*Policy Holder's Social Security Number:*	
Policy Holder's Employer's Name:		*Annual Insurance Deductible:*	
Insurance Co pay:		*Max out of Pocket:*	
Prefix:	*Suffix:*	*ID #:*	*Group #:*

I attest that my personal information is correct and filled out completely.

Parent / Guardian Signature:	*Date:*

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

AUTHORIZATION TO RELEASE INFORMATION

Date:

Client Information

Name: DOB:

I understand this release is voluntary and applies to all programs and services operated under Ready Set Connect.

I hereby authorize Ready Set Connect to (check all that apply):

☐ Exchange information with

☐ Release information to

☐ Obtain information from

The following Insurance Company regarding the above-named client:

Name of Organization/Individual:

Address:

City: State: Zip:

I hereby authorize this information to be exchanged in the following manner:

☐ Verbal only

☐ Written form only

☐ Both verbal and written communication

Description of information to be exchanged / released / obtained (select (select all that apply):

☐ Education records

☐ Evaluation/assessment/eligibility records

☐ Medical records

☐ Financial Information (any applicable financial information that pertains to services)

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Child's Name:		Date of Birth:
Primary Care Provider:	Phone:	Fax:
Diagnosing Provider:	Phone:	Fax:
School:	Phone:	Fax:
Name:	Relation:	Phone:
Name:	Relation:	Phone:
Name:	Relation:	Phone:

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

Other:

This information is to be used for diagnostic, treatment-planning, and continuity-of-care purposes only. This release will remain in effect for one (1) year unless otherwise stipulated or revoked in writing.

From (MM/DD/YYYY): To (MM/DD/YYYY):

Client of Parent/Guardian Printed Name: Date:

Client of Parent/Guardian Signature: Date:

Records Released by: Date Released:

Insurance authorization and billing procedures require us to send a copy of the clinic reports to the primary care physician or to the physician who referred you or your child for services. We support this practice, which facilitates continuity of care.

Insurance Contact Information

Katherine Dunn
Billing Specialist
kdunn@readysetconnect.org
603-333-2888

Natalie Kitching-Rajak
Insurance & Billing Manager
nkitching@readysetconnect.org
603-333-2880

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Policy and Consent Information Form

Telephone Communication Policy

Ready Set Connect may leave voicemail messages at the telephone numbers provided by you unless you indicate otherwise in writing. All messages will be limited to information necessary to facilitate communication and will be left in a manner that respects your privacy and confidentiality.

Payment Information and Financial Policy

You may choose to pay for services privately or utilize available insurance benefits, when applicable.

While Ready Set Connect will verify insurance benefits and obtain required authorizations when possible, verification of benefits and authorization of services do not guarantee payment by your insurance carrier. Coverage varies by plan, and not all services provided by Ready Set Connect are covered under every insurance policy.

As the parent, guardian, or responsible party, you are responsible for:

- Confirming that ABA services are covered under your insurance plan.
- Understanding your deductible, copayments, coinsurance, and out-of-pocket responsibilities.
- Notifying Ready Set Connect immediately of any changes to your insurance coverage, policy information, or benefits.
- Ensuring that all insurance information provided to Ready Set Connect is accurate and current.

Any charges denied by your insurance carrier, determined to be non-covered services, or otherwise deemed the financial responsibility of the member will remain the responsibility of the parent, guardian, or responsible party.

Signature Acknowledgment

Your signature is required to acknowledge your understanding of and agreement with the following authorizations and consents. Please review each section carefully. If you have any questions regarding this form, please contact Ready Set Connect prior to signing.

Authorization for Release of Information

I authorize Ready Set Connect, LLC to release relevant clinical information, reports, evaluations, treatment plans, and progress updates to my child's primary care physician, referring provider, and other authorized healthcare professionals involved in my child's care, as permitted by applicable privacy laws and any additional authorizations I have provided.

I understand that this authorization may be revoked at any time by submitting a written request, except to the extent that action has already been taken based upon this authorization.

Consent for Assessment and Treatment

I voluntarily consent to assessment, treatment, consultation, and related ABA services provided by Ready Set Connect clinicians, including Board Certified Behavior Analysts (BCBAs), Registered Behavior Technicians (RBTs), and other qualified clinical staff operating within their scope of practice.

If signing on behalf of a minor or dependent individual, I certify that I am the legal parent, guardian, or authorized representative and have the authority to provide consent for services.

I understand that I may withdraw this consent at any time by providing written notice to Ready Set Connect.

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Insurance Benefits and Parent Financial Responsibility

Ready Set Connect will make reasonable efforts to verify insurance eligibility and benefits prior to initiating services. However, insurance benefits are subject to change and verification is not a guarantee of coverage or payment.

As the parent, guardian, or responsible party, I understand and agree that:

- I am responsible for understanding my insurance benefits and coverage limitations.
- I am responsible for verifying my deductible, copayment, coinsurance, and any other out-of-pocket costs.
- I must notify Ready Set Connect immediately of any changes to my insurance coverage, policy status, subscriber information, or benefit structure.
- I am responsible for ensuring that all insurance plans covering my child are properly coordinated and reported to Ready Set Connect, the health plan, and any applicable state agencies, including Medicaid.
- Insurance authorizations are not guarantees of payment. Final payment determinations are made solely by the insurance carrier.
- I am financially responsible for any services denied by insurance, services determined to be non-covered, services rendered after coverage has terminated, or any patient-responsibility amounts identified by the insurance carrier.
- If a change in treating clinician occurs, Ready Set Connect will make reasonable efforts to notify me in advance. I understand that it is my responsibility to verify network participation and coverage with my insurance carrier if required by my plan.
- Failure to maintain active and accurate insurance information may result in delayed services, denied claims, or financial responsibility for services rendered.

By signing below, I acknowledge that I have read, understand, and agree to the policies and responsibilities outlined in this document.

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Insurance Responsibility

Parents/guardians are responsible for notifying Ready Set Connect (RSC) of any changes to their address, insurance coverage, policy information, subscriber information, or eligibility status before the effective date of the change whenever possible.

While RSC may assist with benefit verification and authorization requests, it is the sole responsibility of the parent/guardian to understand, maintain, and manage their child's insurance benefits and coverage. RSC is not responsible for monitoring changes in insurance eligibility, benefits, plan requirements, or network participation.

Parents/guardians are financially responsible for all:

- Copayments
- Coinsurance amounts
- Deductibles
- Non-covered services
- Denied claims
- Missed appointment fees
- Late cancellation fees
- Any balances resulting from inaccurate, inactive, or unreported insurance information

Failure to notify RSC of insurance changes may result in claims being denied and financial responsibility for services rendered. Any balance incurred due to unreported insurance changes, coverage termination, claim denials, or insurance processing issues will be the responsibility of the parent/guardian.

In some cases, insurance carriers may issue payment directly to the parent/guardian. If this occurs, the parent/guardian must notify RSC immediately and forward the payment to RSC. Insurance payments intended for services provided by RSC should not be deposited or cashed by the parent/guardian. If such payments are retained or cashed, the corresponding balance will be billed to the parent/guardian and will be due within thirty (30) days of the statement date.

Payment is due within thirty (30) days of the statement date. If an outstanding balance reaches $500 or more, RSC reserves the right to place services on hold until the account balance is paid in full or satisfactory payment arrangements are established.

Emergency Medical Care

In the event of a medical emergency requiring immediate treatment, RSC will make every reasonable effort to contact the parent/guardian or designated emergency contact prior to taking action.

If emergency medical treatment is necessary, the child will be transported to the nearest appropriate medical facility. The parent/guardian is responsible for all costs associated with emergency medical treatment and transportation.

Cancellation and No-Show Policy

To avoid cancellation fees, appointments must be canceled at least two (2) hours prior to the scheduled appointment time.

A fee of $25.00 may be assessed for:

- Failure to attend a scheduled appointment (No-Show)

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

- Cancellation with less than two (2) hours' notice
- Arriving more than fifteen (15) minutes late for a scheduled appointment when services cannot reasonably be provided

These fees are not billable to insurance and are the sole responsibility of the parent/guardian. Payment is due within thirty (30) days of the invoice date.

Repeated cancellations, no-shows, or chronic attendance concerns may result in a review of service eligibility and scheduling availability.

Medicaid Verification and Eligibility

Families utilizing Medicaid benefits must provide documentation verifying active Medicaid eligibility at intake, including the New Hampshire Department of Health and Human Services (DHHS) Notice of Decision or other acceptable eligibility documentation.

Parents/guardians are responsible for providing updated Medicaid eligibility documentation annually at their redetermination date and whenever requested by RSC.

Additionally, parents/guardians must notify the RSC Insurance and Billing Department immediately of any changes that may impact Medicaid eligibility or Managed Care Organization (MCO) enrollment, including but not limited to:

- Changes in household income
- Changes in family composition
- Changes in address or residency
- Changes in Medicaid eligibility status
- Changes in MCO enrollment

Please note that Medicaid eligibility and MCO assignments may change before an annual redetermination based on information reported to DHHS.

Because ABA services require prior authorization, uninterrupted coverage is critical. Failure to promptly report eligibility or coverage changes may result in delays, interruptions, claim denials, or financial responsibility for services rendered.

At this time, RSC accepts the following New Hampshire Medicaid Managed Care Organizations (MCOs):

- New Hampshire Healthy Families
- WellSense Health Plan
- AmeriHealth Caritas New Hampshire

RSC does not accept traditional ("straight") Medicaid.

Acknowledgment

I acknowledge that I have received, read, and understand the Policy and Consent Information Form. I understand my responsibilities regarding insurance coverage, financial obligations, appointment attendance, emergency procedures, and Medicaid eligibility requirements.

Parent/Guardian Name (Printed)

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Parent/Guardian Signature

Date

Client's Name:	
Parent / Guardian Name:	
Parent / Guardian Signature:	*Date:*

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Scheduling and Services Information Form

Scheduling Preferences

Please complete the schedule below to indicate your preferred days and times for your child's services at Ready Set Connect (RSC). This information helps our scheduling team understand your family's availability and service preferences.

Please note: The schedule you provide is a request and is not guaranteed. Final service hours, frequency, and scheduling recommendations are determined by clinical assessments and medical necessity, as established by your child's Board Certified Behavior Analyst (BCBA) after the initial evaluation.

Hours of Operation
Ready Set Connect Hours of operation are:
Monday through Friday
8:00 AM – 5:00 PM
Weekend sessions as needed to make up any hours lost during the week

If you do not wish for your child to attend services on a particular day, please indicate "N/A" in the corresponding section of the schedule.

While family preferences are carefully considered, all service schedules are ultimately based on clinical recommendations and medical necessity.

Typical Scheduling Guidelines

Children under 6 years of age typically attend services during daytime hours, generally between 8:00 AM and 3:00 PM. School-aged children typically attend services after school hours, generally between 3:00 PM and 5:00 PM.

To support treatment goals and maintain clinical consistency, school-aged clients are generally expected to attend at least (at a minimum) two afternoon/evening sessions per week, when clinically appropriate.

Our team will work closely with your family to develop a schedule that supports your child's treatment needs while considering availability and program capacity.

Day of the week	***Drop off at RSC (Time)***	***Pick up from RSC (Time)***
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

School Contact Information

School Name:	*School Phone Number:*
School Address:	*Teachers Name:*
Name of other contact person who knows your child:	*Does your child have a current IEP?*

If your child has an IEP, please provide a copy of the current IEP with the intake paperwork.

School Schedule and Services

Type of Services in School:	***Hours per week:***	***Schedule Of Services:***
School Hours per day		
Paraprofessional		
Speech		
Occupational Therapy		
Physical Therapy		

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Early Intervention Services

Early Intervention Services:	***Hours per Week:***	***Site of Therapy:***
Home visitor		
Center-based individual visit		
Child play group		
Parent support group		
Other (please describe)		

Therapeutic Services

Therapeutic Services:	***Hours per week:***	***Site of Therapy:***
Individual speech therapy		
Group speech therapy		
Occupational therapy		
Physical therapy		
Counseling or psychotherapy		
Social skills group		
Other therapies		

Medical Information and Family History Form

General Medical Information

Please List any Parental Concerns:

Medical, Developmental, or Mental Health Diagnoses (Diagnosed or Possible):

Diagnosis	*Diagnosis Date*	*Provider Name*	*Do you Agree?*

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Medications

Please list any medications taken, including dosage and frequency:

Allergies

Please list any allergies:

Family History

Does anyone in the child's family (blood relatives) have any of the following conditions? **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	

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Request and Authorization for Pick-up Form

Your child will be released only to the person(s) listed on your authorization form. Please advise family and friends that identification will occasionally be required.

Please notify the office if there are any changes in pick-up plans or arrangements, or changes to the authorization.

Child's Name:		
Name:	*Relation:*	*Phone:*
Name:	*Relation:*	*Phone:*
Name:	*Relation:*	*Phone:*
Parent Signature:		*Date:*

Photo, Video, and Media Release Authorization
Participant Name: _____
Parent/Guardian Name (if applicable): _____
Date: _____

Purpose of Authorization

Ready Set Connect ("RSC") requests your permission to photograph, video record, and/or audio record you or your child for educational, informational, promotional, and organizational purposes.
Media may be used in, but is not limited to, the following:

- RSC website and social media platforms
- Printed marketing materials, brochures, flyers, and newsletters
- Educational and training materials
- Community outreach and awareness initiatives
- Presentations, publications, and internal communications
- Fundraising and promotional activities

Authorization and Consent

I hereby grant Ready Set Connect, its employees, representatives, and authorized agents' permission to photograph, video record, and/or audio record me or my child.
I further authorize Ready Set Connect to use, reproduce, edit, publish, display, distribute, and otherwise utilize these photographs, recordings, or media assets in any format or medium, whether currently existing or developed in the future, for the purposes described above.
Initial Here _____

Client Name:

Date of Birth:

Member ID #:

I understand and agree that:

- Participation in photographs, videos, or recordings is voluntary.
- No compensation, royalties, or other payment will be provided for the use of these materials.
- All photographs, recordings, and media assets become the property of Ready Set Connect.
- RSC may edit, crop, or otherwise modify media materials as needed for their intended use.
- This authorization will remain in effect unless revoked in writing.
- Revocation of this authorization will apply only to future uses and cannot be applied retroactively to materials that have already been published, distributed, or produced.

Privacy and Confidentiality

Ready Set Connect is committed to protecting the privacy of its clients and families.
Unless separately authorized, RSC will not intentionally disclose protected health information (PHI), confidential clinical information, or personally identifying information in connection with any photograph, video, or recording, except as permitted or required by law.

Consent Selection

Please select one:

☐ YES – I authorize Ready Set Connect to photograph, video record, and/or audio record me or my child and to use these media assets for the purposes outlined in this authorization.
☐ NO – I do not authorize Ready Set Connect to photograph, video record, and/or audio record me or my child for any purpose beyond treatment-related documentation as permitted by law.

Signature

I acknowledge that I have read and understand this Photo, Video, and Media Release Authorization and voluntarily agree to the selection indicated above.

Participant or Parent/Guardian Signature:

Printed Name:

Date: _____

Relationship to Participant (if applicable):

Questions?

If you have any questions regarding this authorization, please contact:

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Privacy Notice

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.
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 this notice to Ready Set Connect LLC. Your signature is required before services can be initiated.

Ready Set Connect LLC 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 LLC 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 LLC 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 the 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 LLC may use confidential information to provide you with appointment reminders or information related to treatment alternatives. Additional activities may include assessing and designing program activities and/or generating informational mailings. A consumer may request removal from the Ready Set Connect mailing list by calling the privacy officer at 800.932.5837.

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

4. We will disclose health information about you when required by federal, state, or local law.
5. We may disclose health information related 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, and 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 chart will be conducted in the presence of a Ready Set Connect LLC staff member.

Client Name:

Date of Birth:

Member ID #:

2. You are entitled to receive confidential information about your protected health 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 in accordance with the organization's policies and procedures. Please note that Ready Set Connect LLC 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 LLC is not obligated to agree to the requested restriction. We are, however, required to consider the request and inform you of our decision.

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 LLC

- or -

Secretary of the United States Department of Health and Human Services

---

How Ready Set Connect May Use or Disclose Your Health Information

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. Ready Set Connect will need to use and disclose personal health information for treatment, payment, and health care 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 the training and supervision of staff members.
    1. 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

Client Name:

Date of Birth:

Member ID #:

provide the services you requested or to process essential functions such as billing, accounting, quality assurance, or legal and financial activities.

2. 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 assessing and designing program activities and/or generating informational mailings. A consumer may request removal from the Ready Set Connect mailing list by calling the privacy officer at 800.932.5837.
3. We will disclose health information about you when required by federal, state, or local law.
4. We may disclose health information related to adverse events with respect to product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.
5. 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.
6. 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.
7. 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.
   c) In response to a request from law enforcement, if certain conditions are satisfied.

Uses and Disclosures of Protected Health Information Based on 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.

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

Client's Name:	
Parent / Guardian Name:	
Parent / Guardian Signature:	*Date:*

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Telemedicine Consent

Parents are encouraged to call their insurance and verify which place of services your insurance covers, as well as telehealth benefits. There is no guarantee that telehealth will be covered, and you will want to notify RSC whether you have coverage at intake. It is also the parents' responsibility to check annually to ensure that telehealth remains a covered service. All costs associated with telehealth are the parents' responsibility.

I consent to my child receiving Telemedicine in the use of interactive audio, video, or other electronic media for the purpose of consultation, parent training, and BCBA supervision treatment.

Parent / Guardian Signature:	*Date:*

Parent Responsibility Coverage Knowledge Form

Parents (or legal guardians) are ultimately responsible for understanding their child's insurance policy, including any requirements related to autism services, such as the need for a Comprehensive Diagnostic Evaluation (CDE). Here is a clear breakdown of what that responsibility entails and how you can manage it.

Knowing What's Covered

You need to understand:

- Whether your plan covers ABA therapy, coverages including telehealth, and in/out of network status
- What requirements are tied to those services (e.g. a diagnosis from a specific type of provider, severity levels, or recertification timelines).
- If a recent CDE (e.g., within 3 years) is required for authorization or continuation of services

Keeping Track of Documentation

- You should know when your child's last CDE was completed.
- Keep a copy of the diagnostic report, as it may be needed for reauthorization or appeal

Understanding Plan-Specific Rules

- Each insurance plan can have different:
    - Coverage levels
    - Network restrictions
    - Reevaluation requirements
    - Prior authorization procedures
    - That means what's true for one family may not apply to another, even with the same insurer.

Communicating With Providers

- Your ABA provider, therapist, or pediatrician may remind you about upcoming expirations of documentation, but it is not legally their responsibility to ensure your paperwork is up to date.
- Some providers help manage this, but if something is missing, the claim denial will affect your child, not the provider.

Staying Ahead of Reauthorization

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

- If your plan requires a new CDE every 3 years, it's your responsibility to schedule it in advance, since waitlists for autism evaluations can be long.

Communication Surrounding Insurance Change:

ABA Authorization is Plan-Specific. A new insurance plan does not automatically transfer authorization from the old one. Each insurance plan has its own rules for:

- Coverage of ABA therapy
- Approved providers (in-network vs. out-of-network)
- Prior authorization process
- Required documentation (e.g. CDE age limit, treatment plan format)

Delays Can Cause Service Gaps

If you don't inform your provider or insurer promptly:

- Therapy may be paused until new authorization is obtained.
- Your ABA provider may not be able to bill the new insurance.
- You may have to restart the entire approval process, which can take weeks or months.

You May Be Liable for Costs

If services are provided without updated authorization under the new insurance:

- The claim may be denied.
- You (the parent/guardian) may be billed in full.
- Retroactive authorizations are not guaranteed, especially with Medicaid or strict commercial plans.

When to Notify

- Immediately after you know your insurance is changing
- Before the current plan ends or the new one starts
- As early as possible if there's a known gap (e.g. job switch, open enrollment)

Who to Notify

- Your ABA providers' Billing and Insurance Manager – Natalie Kitching-Rajak
- New insurance company (to verify benefits and ask for coverage rules)
- Behavioral health case manager (if assigned)
- Old insurer (if they're still processing claims, or if COB is required)

I certify that I have received a copy of the Parent Responsibility Coverage Knowledge Form.

Client's Name:	
Parent / Guardian Name:	
Parent / Guardian Signature:	*Date:*

Initial Here _____

Client Name:

Date of Birth:

Member ID #:

Parent / Guardian Handbook Acknowledgment Form

I acknowledge that I have received and read the Ready Set Connect Parent Handbook and that I understand its contents. I agree to follow the policies and procedures outlined in this handbook and understand that they are designed to provide a safe, structured, and supportive environment for my child. I understand that I can contact my child's team with any questions or concerns for further clarification.

Client's Name:	
Parent / Guardian Name:	
Parent / Guardian Signature:	*Date:*

Initial Here _____