CLIENT'S INFORMATION

CLIENT NAME	
DATE OF BIRTH	
INSURANCE ID	
CASE NO.	
INSURER PRIMARY	
HOME PHONE	
CELL PHONE	
WORK PHONE	
ADDRESS	
AGE	
LANGUAGE	
PROFESSION	
EDUCATION	
GENDER	
REASON FOR REFERRAL	To receive Behavior Analysis
AGENCY	Services **ABA SW FL**
INSURER SECUNDARY	N/A

EMERGENCY INFORMATION

PARENT/GUARDIAN NAME	
RELATIONSHIP	
CELL PHONE	
EMAIL	
Date	

ASSESSMENT DATE:	TBD
ANALYST/CONSULTANT	Sucel Tejeda

Agency: ***ABA OF SOUTHWEST FLORIDA CORP***

Required Documentation Receipt

Client Name: ________________________________

Please mark **if** a copy is provided

- [x] Demographic Information Form
- [x] Consent for Service
- [x] Client Bill of Rights Acknowledgement
- [x] Client Responsibilities
- [x] Financial Agreement Policy
- [x] Service Time Agreement
- [x] Authorization for the Release of Information
- [x] Consent for Media Records
- [x] Grievance Procedure
- [x] Health Information Privacy Notice (HIPAA)
- [x] Financial Policy Agreement
- [x] Reporting Insurance Fraud
- [x] Reporting Abuse/Neglect/Exploitation
- [x] Limited English Proficiency Notice
- [ ] Yearly Client Preferences Form
- [ ] Dual Satisfaction Survey and Validation

I, ____________________________________, received a clear explanation of the documents mentioned above and all of my questions regarding these documents were answered to my satisfaction.

Client/Legal Guardian Signature: ________________________________

Date:

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ______________________________

CLIENT CONSENT FOR SERVICES, TREATMENT, BEHAVIOR PLAN AND CANCELLATION

I certify that I have authority to legally consent to assessment, release of information, and all legal issues involving
Upon request, I will provide proper documentation of guardianship. If my status as legal guardian should
change, I will immediately infoı ABA OF SOUTHWEST FLORIDA CORI and provide:
the name, address, and phone number of the person(s) who have assumed that role.

I hereby give consent for this agency to provide the following services (as well as any others not indicated below):

- Assessments
- Re-assessments
- BASP
- BASP Updated
- Treatment
- Incident Report
- Discharge

I autorize ABA OF SOUTHWEST FLORIDA CORP to provide services at the following location:

☑ Home ☑ School ☑ Community ☐ Other________________

School Name:___________________________
I acknowledge that it is my responsibility to act in response to the treatment recommendations made as a result of the assessment and that are documented on my Behavior Plan. I understand that my request for receiving behavior analyst services is documented in my support plan/initial and ongoing assessments.
I understand that by signing, I am giving consent to the implementation of the treatment procedure specified to communicate therein. The risks and benefits of the procedures have been clearly stated and I understand them, I also consent to allow ABA OF SOUTHWEST FLORIDA CORP to obtain services and information during the course of treatment. I understand that if I fail to comply with the treatment recommendations, services may be terminated.
I understand that I have the right to refuse to sign this consent and/or refuse to give consent. I can also retract or withdraw consent at any time. I can also cancel services from the ABA agency at any time without interference or retaliation.
Further, withdrawal or retraction of any of the different types of consents does not waive the other consents unless explicit that all consents are waived and/or cancellation of services is indicated.

______________________________ ______________________________
Client/Legal Guardian Name Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ______________________________

Client Bill of Rights

A. To be treated with dignity and humane care.
B. To have impartial access to services, regardless of race, religion, sexual orientation, ethnicity, age, national origin, medical or mental condition, economic or marital status, political affiliation, creed, gender, developmental disability or veteran status.
C. To have a private communication with any staff and privacy of treatment record.
D. To have access to treatment record upon request.
E. To religious freedom and practice.
F. To social interaction and participation in community activities.
G. To physical exercise and recreational activities.
H. To participate in the development and implementation of the treatment plan, evaluate plan and request changes.
I. To request a change of staff or termination of service through a discussion of your request with your service provider.
J. To have a clear explanation of how to lodge complaints, grievances, or appeals.
K. To have appropriate and prompt medical treatment/services within available resources.
L. To referrals to other community services and advocacy on your behalf to ensure the coordination of services and optimal benefits.
M. To have an individualized treatment regardless of the source of financial support.
N. To be provided with sufficient information and training on the behavior analysis program and services to make an informed choice about using the agency and its services.
O. To timely communication in a professional manner.
P. To be fully informed of rules, regulations, expectations and other factors applicable to the client's conduct which may result in termination of services.
Q. To be serviced by highly trained staff members who will follow program guidelines.
R. To continuity of care and support in the event a change occurs during the service period.
S. To be free from harm including unnecessary physical, chemical or mechanical restraint, isolation, excessive medication, abuse or neglect.
T. To be informed of client's rights in a language I understand.

______________________________ ______________________________

Client/Legal Guardian Name Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ___________________________________

Client/Legal Guardian Responsibilities

A. To be actively involved in the development and implementation of Behavior Analysis/Assistant services by being at home at scheduled time, working with the Analyst for the entire session unless directed otherwise, completing assignments as required, making changes in the environment as written.

B. To provide accurate information on all forms and requests for information.

C. To refrain from violent or threatening behavior or language.

D. To refrain from the use of mood altering substances during the course of services.

E. To accept and comply with referrals to another service provider, including Physician consultation.

F. To notify of any change including an illness or other emergency.

G. To collaborate with agency on any applications for grants or scholarships to help cover and pay for services.

I have read a copy of my responsibilities as a recipient of this agency services and they have been explained to my satisfaction. I understand that if I fail to comply with the above responsibilities, services may be terminated.

___________________________________ ___________________________________

Client/Legal Guardian Name Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ___________________________________

Assigment of benefits

I hereby authorize and request that payment of benefits by my primary insurance company
and my secondary insurance : **N/A** be made directly to ABA OF SOUTHWEST FLORIDA CORP
for services furnished to me or my dependent. I understand that my insurance company may only cover a portion
of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.
In addition, I authorize ABA OF SOUTHWEST FLORIDA CORP to disclose any and all written information from
the above named insurance company and/or its designated representatives, at the determination of
ABA OF SOUTHWEST FLORID Such disclosure shall be for reimbursement purposes for those services received.
I hereby release, ABA OF SOUTHWEST FLORIDA CORP its officers, agents, employees and any clinical staff
associated with my case, from all liability that may arise as a result of disclosure of information to the above named
insurance company(s) or their designated representatives.
By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
2. I agree to participate and assist ABA of SWFL Corp. or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at anytime except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. ABA of SWFL Corp. is acting in filing for insurance benefits assigned to ABA of SWFL Corp. and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).
6. A firm contracted by ABA of SWFL Corp. for billing and collection purposes may do billing.
7. ABA of SWFL Corp.is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
8. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
9. ABA of SWFL Corp. shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

___________________________________ ___________________________________

Client/Legal Guardian Name Printed Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ____________________________

Service Time Agreement

Therapy service hours will be agreed upon with client and caregivers. Hours agreed upon shall
shall normally be at any time between 7:00 AM to 9:00 PM any day from Monday through Sunday depending on client's necessity and availability.
Hours of service will be scheduled prior to starting therapies, In the event of any reschedruling or cancelations, prior notice is therapies were to be given on a different time, they will be agreed upon by both consumer and therapist.

I have discussed time and location and would like to receive behavior analysis services

The office:
will be closed on the following dates:

- New Year's Day
- Martin Luther King Day
- President's Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

Every other day, unless specified by office personnel, the office will be open Monday through Friday from 9:00AM to 5:00PM.

____________________________ ____________________________

Client/Legal Guardian Name Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

AUTHORIZATION FOR RELEASE/OBTAIN OF INFORMATION

Client Name: ______________________________

Client Address: ______________________________
Street City State Zip

Birth Date: ______________ Telephone # ______________

(Initials)_______ I authorize : ABA OF SOUTHWEST FLORIDA CORP
to release/obtain information to/from the following individuals
and/or organizations: Legal Guardian/Caregiver, support coordinator office, school, any other applicable provider/medical staff, and in accordance with any court order

Information to be released/obtained includes those related to: (Please check all that applies)

o Medical Record
o Academic Records and IEP
o Hospital Discharge
o Psychiatric Evaluation
o Psychological Evaluation
o Previous Behavior Service
o Medication
o ADT information
o PCA Services/ Life skills 1 / Life skills 2
o Employment Information/Support Employment services
o OT/ Speech / Physical Therapy
o Vocational Evaluation/Vocational Rehabilitation Informat
o Social Skill Services
o Other: ______________

For the following purpose: **Authorizations and Treatment Progress**

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may rediscover my health information without obtaining my authorization.
This authorization expires within one(1) year of the date it was signed or when the consumer, parent or legal guardian provides revocation in writing, whichever comes first.
I understand that my records may be subject to re-disclosure by recipients and unprotected by federal or state law, and that this authorization remains effective for the time specified above, until you actually receive a signed revocation or until the records retention period required under federal and Florida law has expired, whichever first occurs. I have been given an opportunity to ask questions and have received a copy of the signed authorization. I understand that I may inspect a copy of my protected health information to be used or disclosed under this authorization, that you have not conditioned provision of services to or treatment of me upon receipt of this signed authorization, and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided on this form. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, you reserve the right to deny that health care. I understand that I may inspect or copy the information that is used or disclosed. With regard to my right of revocation discussed above, I may revoke this authorization except to the extent that action has been taken in reliance on this authorization or if this authorization is obtained as a condition of obtaining

A copy of this signed form will be provided to the individual.

______________________________ ______________________________
Client/Legal Guardian Name Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ______________________________

Consent for telehealth services

I, ______________________________, give my permission to the agency Supervisors (BCBAs) to conduct video conference (telehealth) sessions of consumer and/or family during a session. I understand that Video conferences will not be recorded. Only live video is allowed during Telehealth ABA services. Only the RBT and client will be visible during conference for confidentiality purposes.

I have read the statements above and have had all questions regarding the use of these remote tools answered to my satisfaction. Any information that I provide will be strictly confidential as required by the laws of the State of Florida, and will not be shared with any other person(s) or agencies unless otherwise requested through the proper documentation.

______________________________ ______________________________

Client/Legal Guardian Name Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ________________________________

Grievance Procedure

ABA OF SOUTHWEST FLORIDA CORP has a grievance process that allows client, family, and/or guardian to grieve and resolve the actions of program staff, and/or conditions or circumstances that violate their rights without interference or retaliation. All grievances will be recorded using the Grievance Form to be completed by the client, family, and/or guardian. These procedures do not preclude appropriate requests for a hearing in accordance with Chapter 120, F.S., nor do they preempt the individual, family, and guardian's right to request a change in services and/or Provider or request a meeting to discuss other issues of concern. Initially, efforts are made with the client to resolve conflicts and/or complaints informally and verbally by discussing with their Supervisor, Therapist, or designee. If those discussions do not lead to a satisfactory resolution, then he/she has the right to initiate a grievance process by following the steps below:

Step 1: If the grievance is not resolved through initial discussion, the client, family, and/or guardian will have three (3) business days from the date the incident occurred which is the cause for their grievance to complete the Consumer Grievance Form and submit to the Program Director. The Program Director will schedule a meeting with the client, family, and/or guardian within 3 business days from the date the Grievance Form was submitted to them. If the client, family, and/or guardian is not satisfied with the outcome of this meeting, he/she has the right to appeal and proceed with step 2 of the grievance process.

Step 2: If the grievance is not resolved through the meeting with the Program Director, then the grievance will be directed to the client's support coordinator or funding source as the next step of resolution.

Response to grievances will be provided verbally and in writing on the grievance form within 7 days of the complaint being received.

______________________________	______________________________
Client/Legal Guardian Name	Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ______________________________

HIPAA

PATIENTS ACKNOWLEDGMENT OF RECEIPT OF HEALTH INFORMATION PRIVACY NOTICE

ABA OF SOUTHWEST FLORIDA CORP is fully committed to compliance with HIPAA guidelines by abiding to:
- Providing appropriate security for our client files
- Protecting the privacy of our client's protected health information
- Appropriately maintaining our client information and billing processes in compliance with the national HIPAA Standards

In the event in which ABA OF SOUTHWEST FLORIDA CORP or the mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of ____________________________. or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of ____________________________. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify __________________________. (to protect confidentiality). If we reach an answering machine or voicemail we will follow the same guidelines.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

By initializing, I hereby acknowledge that I received the __________________________. Health Information Privacy Notice brochure for my review prior to receiving services and it included the following topics: _______

- Our Legal Duties
- Use of Information
- Duty to warn and protect
- Public Safety
- Abuse
- In the Event of a Client's Death
- Professional Misconduct
- Complaints
- Minors/Guardianship
- Prenatal Exposure to Controlled Substances
- Client/Legal Guardian/Parent Rights

____________________________ ____________________________

Client/Legal Guardian Name Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ______________________________

Reporting Insurance Fraud

Why it is important?

The Insurance program is funded with both state and federal tax dollars. It is designed to pay for health care for low-income and vulnerable Floridians (children, pregnant women, disabled adults and seniors) who need care. When people get benefits they don't deserve, or when providers are paid for services that were not supplied, it wastes your tax dollars and takes services away from those who need them.

What is Insurance fraud?

Insurance fraud means an intentional deception or misrepresentation made by a health care provider with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under federal or state law related to the Insurance fraud. To report suspected Insurance Fraud, please call the office at t **239-691-6482**. Find out if you are eligible for a reward. Callers may request to remain anonymous.

How to report fraud:

You can help protect your tax dollars by reporting suspected fraud by phone, through the Internet or by regular mail. You can do this without giving your name, but if you agree to give your name and other contact information, that helps the investigators to obtain future information.

Before you make a report, be prepared to describe:

- The name of the person you suspect of committing fraud. This might be a person receiving medical benefits or a health care professional hospital, nursing home, or other facility that provides Insurance services
- The Insurance ID number
- The date of services
- The amount of money involved, and/or
- A description of the acts that you suspect involve fraud

______________________ ______________________________________

Client/Legal Guardian Name Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ______________________________

Reporting Abuse/Neglect/Exploitation to the Florida Abuse Hotline

BE PREPARED TO DESCRIBE:

- Victim name, address or location, approximate age, race, and sex;
- Physical, mental or behavioral indications that the person is infirm or disabled;
- Signs or indications of harm or injury, including a physical description if possible;
- Relationship of the alleged perpetrator to the victim, if possible. If the relationship is unknown, a report will still be taken if other reporting criteria are met.

Four ways to report:

- Telephone: 1-800-96ABUSE (1-800-962-2873)
- TDD (Telephone Device for the Deaf): 1-800-453-5145
- FAX: 1-800-914-0004
- Web reporting: http://reportabuse.dcf.state.fl.us

Procedure for Reporting:

NOTIFICATION OF REPORT:

Any consultant who is a witness to or sees evidence of abuse of an individual is required to report this to the Abuse Registry and the Director of the Company.

Those persons who witness the abuse, without delay, must report it to the State Abuse Registry (1-800-96ABUSE). The supervisor shall inform the individual (client) of their civil and legal rights and the right to report abusive practices. Likewise parents or guardians shall be informed.

Abuse is identified as a major incident under the APD, Department of Children & Families, Developmental Services unusual incident reporting, and must be handled as such.

Specific descriptions of the incident are very important. This includes WHO was involved, WHEN and occurred, WHY it happened, the extent of any injuries sustained, and what the victim(s) said happened, and any other pertinent information.

The caller shall further be prepared to disclose the name, date of birth (or approximate age), address or location, race, and gender for all adults and children involved.

This will result in a written report by the consultant which shall be submitted to the Department(s) and support coordinator, if applicable. He/she will verify the facts and the report the information to the APD, Department of Children & Families, Developmental Services designee and Director of the Company.

Any consultant witnessing or having knowledge of the abuse of mistreatment of a client and not reporting it shall be considered an accessory to the act and shall be subject to dismissal and any other repercussions as provided by the funding source and in accordance with State and Federal law.

______________________________ ______________________________

Client/Legal Guardian Name Client/Legal Guardian Signature and Date

Agency: ABA OF SOUTHWEST FLORIDA CORP

Client Name: ________________________________

Notice to Clients
Limited English Proficiency

ABA OF SOUTHWEST FLORIDA CORI complies with executive order (E.O.) 13166, to provide access to provide access to service for persons with limited English. If you need language assistance please let us know and on will be provided to you at no cost.
The agency will make every concerted effort to provide limited English persons with vital documents in various language formats.

Complaints regarding language assistance can be forwarded to:

Alain Hernandez
239-691-6483
GM@ABAOFSWF.COM

I acknowledge and understand the Organization's LEP document.

________________________	________________________
Client/Legal Guardian Name	Client/Legal GuardianSignature and Date

ABA of Southwest Florida Corp
OFF: 239-691-6482
Cell: 239-710-1864
Fax: 1888-391-5328
Email: GM@abaofswf.com
https://www.abaofswf.com/

Dear Client:
We need the following information from the **principal policy holder** on your insurance, if you have any questions please contact our office asap
Please provide this information with a copy of the front and back of the insurance card

Insured Id

Policy Group Name

Policy Group #

First Name

Last Name

Middle Name

Date Of Birth

Gender

Phone

Address 1

Address 2

City

State

Zip