BIS HANDBOOK

Thank you for choosing us at BIS! Our goal is to enable each individual we serve to reach his or her highest potential in life by **overcoming barriers, promoting independence, pursuing achievement, and valuing inclusion**. We utilize proven and positive behavior change strategies to reach this goal while including all team members, friends, and family in the process. We look forward to the opportunity to assist you and your family with quality services.

Behavior Intervention Services 2644 Metro Blvd. St. Louis, MO 63043
Office Phone: 314-395-9375 Fax314-395-9381 Website: www.behaviorinterventionservices.com

Behavior Intervention Services (BIS)

OUR MISSION:

Our mission is to help each individual we serve reach their highest potential in life, by overcoming barriers and promoting independence, achievement, and inclusion. We utilize proven and positive behavior change strategies to reach this goal while including all team members, friends, and family in the process.

OUR VISION:

BIS will give the tools, resources, and support to individuals with special needs to pursue his or her best interests, dreams, and success. The focus of BIS is for consumers to acquire meaningful and lifelong skills that increase: community integration, social relationships, independence in daily activities and overall quality of life. Each individual will be approached with care and will be valued. In all aspects of our work, we incorporate behavioral principles that allow for the reduction and extinction of maladaptive behaviors and the acquisition of lifelong skills. Moreover, we understand the stress and confusion that can be involved with navigating the world of diagnosis, education, treatment, and funding. So, our team of knowledgeable and certified staff is here to help!

And though we are an ever-growing agency, we strive to maintain the benefits of our current environment as we continually expand our services. Along the journey, Behavior Intervention Services seeks to create an exciting, challenging, and rewarding environment that allows our employees and our clients to flourish in both their professional and personal lives.

At Behavior Intervention Services, we're always looking for new ways to
"Defy limits, exceed expectations…"

OUR PRACTICE:

Our agency was founded in 2004 to provide services to individuals of all ages utilizing the principles of Applied Behavior Analysis. The agency has grown over the years to serve hundreds of individuals in the St. Louis and surrounding areas. BIS believes that each individual we serve is unique and valued, and our team of experienced professionals provide behavioral assessments, consultation, advocacy through ISP, IEP, and IFSP meeting participation and also create programming specific to meet the needs of the individuals we serve using these proven principles of Applied Behavior Analysis (ABA). ABA differs from other forms of more traditional "therapy" to utilize environmental strategies to encourage the development of appropriate adaptive behaviors and teach new skills while simultaneously making sure that inappropriate behaviors become non-functional and are reduced and/or eliminated from a person's repertoire.

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BIS has several departments to meet the needs of individuals of all ages, including:

- BIS Sprout Clinic for children ages 2 years to 6 years
- Natural Home Department to provide in home comprehensive services utilizing the principles of Applied Behavior Analysis for children from 2 years through 21 years of age
- Individual Supported Living program for people of all ages, generally funded through the Department of Mental Health. This service includes 1-3 individuals living in a home together with full support by BIS staff around the clock.
- BIS Grow Day Program is a state licensed day program for adults ages 18 years or older to provide a therapeutic environment that focuses on adaptive skill development, volunteer opportunities, social participation, and recreational activities.

Each of our departments (Sprout Clinic, Natural Home, Independent Supported Living, GROW Day Program and First Steps), have access to Board Certified Behavior Analysts (BCBA) or Board-Certified Assistant Behavior Analysts (BCaBA). These providers partner with parents, staff, and other pertinent collaborating agencies to provide ongoing support, training, and program development for all individuals we serve.

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Our Board-Certified Behavior Analysts are **nationally certified and licensed in the state of Missouri.** They are **Master's level** professionals who have specific education and training in the field of ABA. BCBA's can perform: **in-depth functional behavior assessments, skill-based assessments, some diagnostic assessments, treatment plan development, positive behavior support plan development, family/staff training, hands-on client intervention, school consultation, and data analysis and interpretation.** Our BCBAs are able to work in natural homes, schools, residential facilities, hospitals, and other settings. They are **experienced in working with individuals with severe and intensive behavioral needs**, and each holds varying other specialties. Typical clients receiving this service range in age from one year to 80 years of age. All of our BCBAs are able to work with clients **funded through private insurance.**	Our Board-Certified Assistant Behavior Analysts (BCaBA) are **nationally certified and licensed in the state of Missouri**. They are at minimum **Bachelor's level** professionals who have specific education and training in the field of Applied Behavior Analysis. They are able to **perform some skill and behavioral based assessments, treatment plan development, positive behavior support plan development, family/staff training, hands on client intervention, school consultation, and data analysis and interpretation under the supervision of a BCBA.** Our BCaBAs are able to work in natural homes, schools, residential facilities, hospitals and other settings. They are **experienced in working with individuals with severe and intensive behavioral needs**. Typical clients receiving this service range in age from one year of age to 80. Most of our BCaBAs are able to work with clients **funded through private insurance with guidance from a supervising BCBA.**

Our staff are fully background checked and comprehensively trained to work under the guidance of Licensed (LBA) and Board-Certified Behavior Analysts (BCBA). Please refer to the following websites for a comprehensive list of individuals licensed and certified to practice in the state of Missouri:

https://www.bacb.com/ (national certification registry)
https://pr.mo.gov/ba.asp (state licensure registry)

Our Registered Behavior Technicians implement individualized behavior plans, teach new skills and support the client and daily in their home and community. Our RBTs are nationally recognized and certified through the Behavior Analytic Certification Board (https://www.bacb.com)

In addition to being certified and licensed, all staff are also trained and certified in the following:

- CPR
- First Aid
- MANDT crisis intervention

These certifications are all renewed annually for every staff member

And have received additional and ongoing training in:

- Discrete Trial training
- Behavior Management

In order to be approved for clinic services, your child must first be assessed by a Board-Certified Behavior Analyst (BCBA) with the assistance of a Registered Behavior Technician (RBT). Working together, they will utilize one of many assessments (VBMAPP, ABLLS, PEAK, Vineland, etc.) to develop a treatment plan with goals and objectives that are individual to your child's skill strengths and deficits. Once a treatment plan has developed, your BCBA will work with you to determine the appropriate level of service including hours each day or week that are required and service times.

Following an assessment, the BCBA will seek to gain approval for ongoing services through your insurance company or funding source. Once an authorization has been granted by your insurance company, your child may begin attending the clinic. Every six months it is the responsibility of the BCBA to re-evaluate your child and develop a new treatment plan with new goals and objectives based upon the progress made in the prior six months of service.
Behavior Intervention Services will collaborate with any other professionals that work alongside your child (SPL, OT, PT) to develop a comprehensive approach to your child's therapeutic experience. Other ancillary services may be provided in our clinic or in your home outside clinic hours.

It is critical that BIS always be informed of any changes in insurance plans immediately as they can greatly impact services and clinic attendance.

EXPECTATIONS OF SERVICES:

BIS always seeks to provide high quality services and professionalism of staff. We believe that we provide these services for our clients at the highest levels. If at any time you have a concern, please do not hesitate to reach out to our Clinic Director or Clinic Coordinator. You may also reach out to the Executive Director of BIS for any concerns at:

Dawn Schmitt
2644 Metro Boulevard
Maryland Heights, MO 63043
314-395-9375

Welcome to the Sprout@BIS Early Childhood Clinic! The first day of clinic is an exciting milestone in your child's life. Your child is embarking on a journey that will lead them on many roads of discovery and learning. As wonderful as this new experience may be, it can also be quite stressful for the young child. New situations and change can, at times, be unsettling for all of us. For many children this may be their first experience of separation from their parents or caregivers at home.

It is not uncommon for your child to be apprehensive during their first week of in-clinic services- as they get used to the change in schedule and transition. Rest assured, we will work with your family and other service providers (at your request/release) to make this transition as seamless as possible.

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HELPFUL TRANSITION TIPS:

We have provided a few suggestions for assisting your child during this new and exciting time in his or her life:

- Prepare your child for the new experience by explaining what to expect. Answer all questions directly and honestly.
- Convey a positive attitude. Young children are aware of your feelings. Your enthusiasm will assure the child the clinic can be a fun and exciting place.
- Establish a routine involving both the night before clinic day as well as morning preparation. Rituals and routines will add predictability and are comforting in unfamiliar situations.
- Bring a small item from home. This is acceptable and often reassuring in helping the child with the initial adjustment to a new place. This item may be a treasured blankie or even a photo from home.
- Clearly state to your child where you will be and when you will return. It may also be helpful to discuss what will happen when you are reunited.
- Maintain a clear good-bye routine. This may include warning the child you are leaving in 3 minutes, a kiss and hug, or a wave from the window. Once you tell your child you are leaving, it is important to follow through. Extending the good-bye with, "Ok just one more kiss, and then I really have to go" tends to heighten anxiety rather than relieve it. Avoid sneaking out, as this seems to encourage children to become less trusting and make the second day of school even harder.

Again, please know we are here to help make the first day of clinic a happy transition. Welcome!

WHAT TO BRING (ITEMS ARE SUGGESTED AND AS NEEDED):

Please label all of the items that you provide.

- Wipes
- Diapers or underwear
- Extra set of clothes in large Ziplock bag
- Blanket
- Stuffed animal
- Glasses
- Communication device
- Medications including EPI pens and inhalers ***
- Any programming materials that may go back and forth
- Snacks
- Lunch for full day participants

*** (Any medication that is expected to be administered at the clinic must be signed off on by your physician and will be administered by a person who is certified in medication) administration (level one med-aide certified).

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INSURANCE FUNDING INFORMATION:

House Bill 1311 requires Missouri health insurers to provide coverage for autism in general, and for applied behavior analysis (ABA) for insured 18 years of age and younger.

Although this bill covers all state and federal plans, self-funded plans are not required to cover ABA services for children, even with a diagnosis of Autism Spectrum Disorder. Self-funded plans may opt out of this coverage.

For those plans that do provide coverage of ABA services, there are often limits placed on the number of hours/visits that we as an agency are authorized to provide to your child. To help ensure that your son or daughter receives the number of services they are due, call the customer service phone numbers located on the back of their insurance card to request an explanation of benefits specifically relating to "Applied Behavior Analysis services for Autism per the Missouri State Autism mandate".

Your BCBA and clinic coordinator will work to ensure that your child has adequate coverage in order to receive services at our clinic, but please understand it is also your responsibility to know your plan and what copays or deductibles might be in place for your plan. Your insurance carrier will generally only cover services that have been authorized and are recommended in your child's treatment plan.

We do understand that families may, at times, request services beyond what their insurance company or other funding source has authorized. BIS will work only within the authorized services dictated by these funding sources unless your family makes a request otherwise. If you choose to exceed your authorized services, you will be financially responsible for any additional services provided. For individuals opting to private pay for services, there will be a separate contract outlining a payment agreement.

Insurance will be utilized as authorized per the insurance company to cover RBT and BCBA hours. BCBA will conduct a functional assessment to recommend the number of hours needed.
Please be aware that you are financially responsible for all copays, coinsurance, deductibles and non-authorized services. BIS or our authorized third-party billing contractor will bill these copays, coinsurance, deductibles, overages and non- authorized service charges to your address when payment has been received from your insurance company.

Should you move, switch employers and/or insurance coverage, receive a new plan under your insurance coverage, or change funding sources, Keeping BIS informed of these changes is important. If another copy of this form is needed, please contact our office or speak with your Clinic Coordinator. Failure to notify BIS of insurance changes will result in the parent paying in full all charges.

Problems or misunderstandings regarding fee payment can interfere with the therapy process. Consequently, it is important that payment arrangements are understood prior to starting in the clinic. If there is no third-party (private insurance) involved, payment is due at the time services are provided. Should a bill reach an outstanding balance beyond 30 days, the child will not be allowed to return to the clinic until full payment has been received.

PATIENT RESPONSIBILITY:

Please initial the following points.

_____I understand and agree that I am financially responsible for all charges for any and all services rendered for my child that may not be covered by insurance.

_____I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

_____I understand and agree that it is my responsibility to know if my insurance requires a diagnosis, referral from a physician, or otherwise for approval of ongoing services.

_____ I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

_____If my child receives Medicaid as a secondary insurance, I understand that I need to provide the office both my Medicaid ID card as well as my primary insurance card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information regarding my child for treatment and payment as required by law. I have the right to revoke this consent in writing. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. Behavior Intervention Services provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Printed Client Name Printed Guardian Name

_____ _____

Guardian Signature Date

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ILLNESS POLICY

Sprout@BIS understands that there will be times a child will be sick. In order to promote the health and safety of all staff and children, it is important that everyone follow Sprout@BIS illness policy. As illness can spread quickly from person to person, we must ensure the wellbeing of all staff and clients. Sprout@BIS reserves the right to send a child home if we feel they are too sick to attend session during the day as limited progress is made when a child is ill. If you choose to keep your child at home for illness, they should be fever and symptom free (as defined below- without medication) for 24-hours prior to returning to Sprout@BIS for ABA therapy. Symptoms that would require a child to remain at or be sent home include (but are not limited to) the following:

- Fever over 99.9 degrees Fahrenheit (must be fever free for 24 hours without medication)
- Vomiting (with or without fever)
- Diarrhea- 2 or more in a day (with or without fever)
- Strep throat
- Head lice (until first treatment and removal of all nits)
- Undiagnosed rash paired with fever
- Ringworm (until treatment)
- Chicken Pox, mumps, measles, varicella, and other contagious diseases
- Conjunctivitis (Pink Eye), if contagious
- Severe cold symptoms (cough, green/yellow mucus, etc.)

Parents are asked to contact Sprout@BIS via text or call on the clinic phone as soon as they know their child will not be attending therapy sessions due to illness as this will have a direct impact on RBT/BCBA schedules. If your child is sent home, for symptoms (as defined above), your child must be picked up within an hour of being notified.

INCLEMENT WEATHER

There may be times when Sprout@BIS determines it would be necessary to have a delayed start, early dismissal, and/or cancellation of services due to inclement weather in the area. This will not necessarily occur even if local schools are closed. All communication regarding inclement weather will be communicated to families by the Clinic Director, Clinic Coordinator, and/or Director of Services.

COMMUNICATION

Sprout@BIS works to provide effective and quality services to the child and their families. Sprout@BIS will provide you with a brief recap of your child's day when you pick-up verbally as well as in writing. Parents, BCBAs, BCaBAs, and RBTs can share information about the child. Additionally, parents are welcome to contact Sprout@BIS clinic via text or call at 314.624.8420.

FAMILY PARTICIPATION AND OBSERVATION

Sprout@BIS views parents as an active participant in their child's programming and expects all parents to attend parent training with a BCBA. Parent training will consist of goals related to their child's skill development and behavior

reduction as recommended in the treatment plan. Research shows in order for any person to acquire specific skills, exhibit less problem behavior, and experience generalization to the home or community environment, active parent and family participation is absolutely necessary. Additionally, for on-going services, insurance companies may require data related to parent training before approval is given.

If you or another service provider would like to visit the clinic, please make arrangements with the clinic coordinator. Visits are only allowed in designated observation areas during DTT due to the laws of HIPAA. BIS does have an observation room in which parents are able to watch a session from a one-way window while the RBT or BCBA works with your child. If you are interested in seeing a 1:1 training session with your child but cannot attend during clinic hours, another option is to schedule a Zoom or Facetime session to observe.

ADMISSION CRITERIA

- Diagnosis of Autism Spectrum Disorder (F84.0)
- Sprout@BIS provides services to children of varying ages and are placed in groups according to age/developmental level
- Information about past and current medications, supplements, including frequency/dosage, must be provided to Clinic Coordinator, Clinic Director, and/or supervising BCBA along with any changes or updates in medications throughout treatment
- Active family involvement in the form of parent/caregiver training as recommended by supervising BCBA

ENROLLMENT

Parents are welcome to call Sprout@BIS to ask questions and be added to the current waitlist (if one). Prior to being moved off the waitlist, families are required to tour Sprout@BIS with the Clinic Coordinator or Clinic Director. The following forms are required during enrollment:

- Admissions including HIPAA, Emergency contacts/pick up, consent to treat
- Insurance cards, Billing consent, and financial agreement
- Confidentiality and Privacy Notice
- Release of Information
- Research Acknowledgement
- Picture and Video Release
- Media Release
- BIS Expectations
- Handbook Acknowledgement

WAITING LIST

Children are enrolled on a first come, first available space basis as it fits with both family and clinic scheduling. Should an individual choose to terminate services and wish to return, they will be placed on the waitlist if no current opening is available.

TREATMENT ASSESSMENT

A child's level and intensity of services varies from individual to individual based upon specific needs determined during assessment including skill deficits across developmental norms and severity of maladaptive behaviors. The supervising BCBA will choose the most appropriate assessments based upon the individual child including but not limited to the Assessment of Basic Language and Learning Skills- Revised (ABLLS-R), Verbal Behavior Milestones Assessment Placement Program (VB-MAPP), Assessment of Functional Living Skills (AFLS), PEAK Relational Training System, or another appropriate assessment to determine the current skill sets and deficits of the child. After assessment, the BCBA will create goals and programming that relates directly to these skill deficits and may include areas such as daily living, communication, social skills, and health/safety.

- Comprehensive Interventions: Services range from 21-40 hours per week. Services are provided in this manner when assessment reveals the need for intervention for multiple targets across most or all developmental domains.

- Focused Interventions: Services are provided up to 20 hours per week and are directed to a more limited set of problem behaviors or skill deficits.

TRANSITION/DISCHARGE

The overall goal of ABA is to provide effective and quality services to an individual, so they develop skills that best meet their overall needs within their current and future environments including the home and community settings and for families/caregivers to provide training to assist with providing the appropriate levels of support.

Throughout an individual's treatment, on-going progress will be assessed and analyzed through data collection on treatment plan goals and behavior data. The supervising BCBA, along with treatment team input, will make updates and modifications to the goals and programming as needed with revisions to the treatment plan at a minimum of every 6 months with progress and assessment updates. Treatment plans/on-going assessments will determine on-going service recommendations including treatment and behavioral goals as well as level/intensity of services.

In-home needs and services will be considered and may be implemented as needed to meet your child's full needs. In-home services focus on empowering and educating the individual and families to implement consistent and effective treatments. Our BCBA's and RBT's work to provide and link programs between in-home, school, day program, community, and other services provided, to coordinate care for the individual.

An individual may be discharged and/or transition from clinic to in-home services for any of the following reasons:

- Individual no longer has availability within clinic hours
- Individual ages out of the program based on current developmental needs
- All skill acquisition goals in the clinical setting have been mastered to criteria and support goals transitioning to a home/community setting for generalization and expansion of skills
- Skill deficits are identified in the home/community setting that are not appropriate to address in a clinical setting
- Individual has attendance that is not in compliance with Sprout@BIS attendance policy
- Individual transfers to another program and/or service provider

- Individual does not comply with financial agreements or declines to work with Sprout@BIS in good faith to resolve outstanding balances

Services may also be discontinued for the following reasons:

- When the BCBA indicates that services are no longer appropriate based on direct observation and data collected during treatment sessions
- Clinical judgment and/or another emergent/crisis,
- It is determined that progress is not being made over authorization period
- When a parent/caregiver chooses to discontinue services.
- It is not appropriate to continue with ABA treatment based on medical issues, family concerns, and/or other factors that may prohibit participation in a clinical setting

Most times, when an individual is discharged it is voluntarily with understanding and a meeting will be held to discuss the discharge plan as well as answer any questions regarding reasoning for discharge. At times, an individual may be discharged at the discretion of the treatment team and/or supervising BCBA for reasons such as failure to comply with treatment and/or treatment being warranted as unsafe to continue. In these instances, services may be discontinued prior to a meeting and/or discharge plan being provided.

Should discharge (not transition) occur, an individual's guardian/parent will be provided with a list of referrals to services with other agencies and support if they feel ABA therapy continues to be a needed service.

WITHDRAWAL

Sprout@BIS requests that families provide a written 30-day notice of intent to withdrawal from the program before the individual's last day. This will allow for the supervising BCBA to complete assessments, make needed changes, review and analyze data, and prepare transition/discharge documents for all appropriate parties involved for the individuals next placement. Without a written-30-day notice, Sprout@BIS cannot guarantee that documents will be prepared accurately or within a timely manner to families in order for the individuals next placement.

ATTENDANCE POLICY

It is the primary goal of Sprouts to provide effective and quality services that are consistent to individuals and their support systems. Because we must ensure that your child is staffed 1:1 by your RBT each day, cancellations result in staff overages. Our RBTs rely on their work schedule and last-minute cancellations do not allow them to fill their work schedule elsewhere.

In order to achieve this, the agreed upon schedule must be observed by all members of the treatment team. We recognize that sessions may need to be cancelled for a variety of reasons such as but not limited to:

- Client cancellations
- Staff cancellations
- Sickness
- Tardiness
- Sessions ending early

- Holidays
- Emergencies

While circumstances outside of our control occur and result in last minute schedule changes, it is the expectation that monthly session adherence will be at or above 85% of all scheduled sessions.

If an individual falls below 85% attendance in any given month, a meeting will be scheduled with the treatment team including guardians to discuss the current schedule and extenuating circumstances. If attendance remains below 85% in any of the following three (3) consecutive months, a 2nd meeting will be scheduled to discuss the following:

- Changes to current schedule
- Reduction of service hours
- Services being put on hold (until a new schedule and/or long-term solution is identified)
- Termination of services (30- day notice, discharge plan, and referrals will be provided)

LATE ARRIVAL POLICY

If an individual is late to their schedule session on 3 or more occasions with-in a 4-week period, session start times will be moved 30 minutes later than the originally scheduled start time. Late is defined as a period of 15 or more minutes. If an individual continues to be late after the session start time has changed, a team meeting will be scheduled to discuss any extenuating circumstances and long-term solutions.

It is the expectation that if a client will be late, the guardian will notify Sprouts clinic via text or call prior to 7:30A. Exceptions will be made on a case-by-case basis dependent upon the circumstances.

LATE PICK-UP POLICY

Every effort should be made to pick your child up at the end of their agreed upon scheduled time. Failure to pick up a child within 10 minutes of any shift end will result in $1.00 charges per minute. **Late fees are due by the following week on Monday**. If an individual is late for pick-up on 3 or more occasions with-in a 4-week period, session times will look to be adjusted accordingly.

EARLY PICK-UP POLICY

It is the goal of Sprout@BIS to provide consistent and effective ABA services to every individual. While we understand there are days parents may want to pick their child up early due to various reasons, we ask that parents limit early pick-ups and provide notification, when possible, via text or call to Sprout@BIS Clinic at least 2 hours prior to any pick up that will be more than 15 minutes early.

CANCELLATION POLICY

BIS requires a **24-hour notice** for any cancellations of services from both individuals and staff, when possible. Should an individual need to cancel a session, they should contact the clinic phone via text and/or email. It is the expectation that any cancelled session (by individual or staff member) will be rescheduled.

BEFORE AND AFTER CARE OPTIONS

Sprouts Clinic can offer before and after care to any child for $100.00 weekly cost from 7:45am to 8:00am and 4pm to 5pm. Any private paid fees are due on Monday mornings before the start of service for the week. Note:

- If you need Before/After Care services, please notify the Clinic Coordinator or Clinic Director a week prior as we need to schedule staff accordingly.
- During the time of before and after care, behavior analytic services will not be given or billed to insurance.
- Late Pick-Up and Cancellation policies apply to before/after care.

Consent for Treatment:

Parents must consent for treatment prior to receiving services. Parents must agree only to those services that the named provider is qualified to perform within the scope of the provider's license, certification, and training, or the scope of license, certification, and training of the behavioral healthcare providers directly supervising the services received. Every treatment plan should be signed off on by a child's parents prior to the start of services to acknowledgement both awareness and agreement on the goals and objectives that have been identified as significant.

Privacy Practices:

Behavior Intervention Services is committed to protecting your child's health information. Please refer to the HIPAA Waiver which DESCRIBES HOW CLIENT INFORMATION ABOUT YOUR CHILD, OTHER MEMBERS OF YOUR FAMILY, OR YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Waiver

Behavior Intervention Services is committed to protecting your health information.

THIS NOTICE DESCRIBES HOW CLIENT INFORMATION ABOUT YOUR CHILD, OTHER MEMBERS OF YOUR FAMILY OR YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A federal regulation, known as the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), requires that we provide detailed notice in writing of our privacy practices.

BIS is committed to protecting health information about your child, you and your family.

- HIPAA requires that we protect health information which identifies a patient or family, information which is called Protection Health Information.
- We will maintain the privacy of all Protected Health Information.
- We give you this notice of our legal duties and privacy practices.
- We reserve the right to change this notice in accordance with current law, and post a copy of such changes in our office in a prominent location, and provide you with a copy of the revised notice upon your request.

How we may use and disclose Protected Health Information without your written authorization or opportunity to agree or object.

- For treatment: We may use and disclose Protected Health Information to provide, coordinate, and manage your child's health care and related services. Examples include disclosure of Protected Health Information when your child requires referral to a physician, health care professional, or hospital, or other specialized testing or therapy
- For payment: We may use and disclose Protected Health Information order to verify your coverage for particular treatment and services and to collect payment for your child's treatment and other services from third-party payers including your health plan, their paid reviewers, and other insurance companies providing you with additional coverage.
- For health care operations: We may use and disclose Protected Health Information in order to help improve the quality of your child's care and reduce its cost. This includes providing training to other health care providers, cooperating with outside organizations which certify the quality of providers or institutions, providing information to professionals who help us improve and maintain the quality and efficiency of the services we provide to your child and to others, resolving grievances which occur within our practice, and converting Protected Health Information to de-identified health information, data which cannot be associated with your child or with other members of your family.
- For communication from our office to you: We may use and disclose Protected Health Information to remind you of appointments and to provide you with information about alternative therapies.
- For compliance with the law: We may use and disclose Protected Health Information to comply with applicable federal, state, or local laws including worker's compensation and Medicare laws.
- For compliance with public health directives: We may use and disclose Protected Health Information to assist public health and other authorities in their efforts to prevent or control communicable diseases, general or school-based injuries, disabilities, and injuries or complications from FDA-regulated medications or devices.
- For prevention and control of abuse, neglect, or domestic violence. We may use and disclose Protected Health Information to properly constituted government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.
- For health oversight activities: We may use and disclose Protected Health Information to a health

oversight agency for audits, investigations, inspections, licensure and disciplinary activities, and other activities necessary to monitor the healthcare system including government healthcare programs.

- For support of legal proceedings: We may use and disclose Protected Health Information when ordered by a court order, subpoena, or discovery requests.
- For support of law enforcement: We may use and disclose Protected Health Information to law enforcement authorities in the patient is a suspected crime victim, if law enforcement authorities indicate that it is necessary to locate a suspect, fugitive, material witness, or a missing person if it relates to a crime or emergency no occurring in the office, and if it is necessary to report a crime and its nature, location, and the identity of those who committed the crime.
- For post-mortem matters: We may use and disclose Protected Health Information to a coroner or medical examiner and, if authorized by law, a funeral director, to allow them to carry out their jobs.
- For selected research activities allowed or required by the HIPAA Privacy Act: We may use and disclose Protected Health Information to governmental agencies for certain research or oversight of our practice and others and to you should you deserve it.
- For prevention of a serious threat to health or safety: We may use and disclose Protected Health Information to an appropriate person about your child or family in limited circumstances to prevent a threat to the health or safety of another person or to the public.
- For support of certain specialized government activities: We may use and disclose Protected Health Information to support certain activities including military maneuvers, executive protection, national security, intelligence gathering, and protection of the health of persons in custody.

ALL OTHER USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION REQUIRE YOUR WRITTEN AUTHORIZATION. AT ANY TIME, YOU MAY REVOKE YOUR AUTHORIZATION, BUT ACTIONS TAKEN PRIOR TO YOUR REVOCATION WILL STAND.

Your rights regarding Protected Health Information about your child and family.

- Right to request restrictions: You have the right to request restrictions on the Protected Health Information that we may use for treatment, payment, and health care operations. To request restrictions, you must make your request in writing to our Privacy Officer using the request form we provide. We are not required to comply with your request if we feel that it is in violation of the above-noted legal directives. In such a case, we will provide you with a written notice of denial.
- Right to receive confidential communications: You have the right to request that you receive communications containing Protected Health Information in a certain manner or at a certain location. You must make your request in writing to your Clinic Coordinator, specifying how and where you would like to be contacted. We are required to accommodate reasonable requests.
- Right to inspect and copy: You have the right to copy or inspect Protected Health Information about you. This does not include Protected Health Information gathered for a civil, criminal, or administrative proceeding. We may deny your request only in limited circumstances. You may take your requests to inspect and copy in writing to our Privacy Officer, and we may charge you a reasonable fee for copying,

postage, labor, and supplies used to meet your request.

- Right to amend: You have the right to amend your Protected Health Information about your child or family as long as such information is kept by or for our office. This request must be made in writing to our Privacy Officer, and you must include a reason for the request.
- Right to receive an accounting of disclosures: You have the right to request an accounting of certain disclosures of your Protected Health Information. This request, in writing to our Privacy Officer, must be for a list of disclosures other than those specified in Section I above made during a time period of up to six years.

_____	_____	_____
Signature (parent/guardian/conservator)	Print name (parent/guardian/conservator)	Date

FORMS

By checking the following boxes, I am agreeing to follow the BIS practices and expectations that are listed.

- ❑ I understand the Sprout@BIS will be held inside of the Behavior Intervention Services office and will NOT be a licensed childcare facility as its sole purpose is to provide ABA therapy to children with Autism.
- ❑ I will have current age-appropriate immunization records for my child on file at the clinic prior to the child's first day of attendance. I have received an immunization requirement schedule and understand that it is my responsibility to comply with these requirements. Any attempt to participate without valid forms will result in immediate suspension from utilizing the clinic until all health requirements are met. Any lapse of services/participation due to immunization compliance could result in a loss of the reserved position and/or schedule.
- ❑ Either party may terminate this agreement with a 30-day written notice. This notice is required prior to change to allow coordinators enough time to fill the space without vacancy. If a child is pulled out, less than a 30-day notice, the guarantor will incur a $150 early termination charge.
- ❑ Children must be picked up daily no later than 4:00pm. Arrangements can be made for pick-up from another approved adult on the Emergency contact list. A family can utilize late pick up or early drop off from 7:30am to 8:00am and 4pm to 5pm for a $100 weekly cost. Payment for this service is due on Monday mornings prior to the week in attendance.
- ❑ I agree to keep my child home if there are any signs of communicable disease and/or fever. I understand for the safety of my child and other children in the clinic it is necessary for sick children to be sent home and not returned until free of any contagions or a doctor's release note is received. A child must be fever free for a period of 24 hours prior to returning to the clinic.
- ❑ I understand the cancellation and no-show policy above.
- ❑ I understand that I am responsible for bringing in all items my child needs. This includes diapers, wipes, lunch, snacks and any other items my child might need during their clinic time. Parents should always be sure to send the child with a change of clothes in the event of an accident.

Emergency Information

Child's Photo:

Name: _____

Parent/Legal Guardian Name (s):

_____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Date of Birth: _____ Gender: _____ Ethnic Origin: _____

Height_____ Weight_____ Eye Color_____ Hair Color_____

Identifying Marks_____ Religious Preference_____

Allergies/Reactions: _____

Any necessary response to allergies: _____

_____

Diagnoses: AXIS I: _____

AXIS II: _____

AXIS III: _____

Communication Style: _____

Primary Language_____

Child Pediatricians Name: _____

Address: _____ Phone Number: _____

Preferred Hospital: _____

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Current Medications: **If medication is required during clinic times additional paperwork is required.**

Medication Name	**Times**	**Dosage**	**Reason**

Emergency Contacts:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Persons allowed to pick up child:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

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BIS CLAIM TRANSMITTAL and FINANCIAL AGREEMENT FORM

	I have no private insurance ☐							
Funding Type:								
A. GUARDIAN INFORMATION								
Phone #:								
Last Name:		First Name:				MI		
Date of Birth:	/ /	Employer Name:						
Home Address:						New Address?	Yes / No	
City:		State:		Zip Code:				
B. PATIENT/CLIENT INFORMATION		Circle here if same as above:		see above				
Last Name:		First Name:				MI		
Date of Birth:	/ /							
Home Address:						New Address?	Yes / No	
City:		State:		Zip Code:				
Sex:	Male / Female			Full Time Student?	Yes / No	School Name:		
C. OTHER INFORMATION								
Is the client's behavioral health covered by an insurance plan?				Yes	No			
(NOTE: Your insurance will not be billed by BIS without your knowledge or consent.)								
Name of person carrying insurance:				Does DMH have this information?				
Name of other insurance Carrier:					Yes	No		
Policy Number:		Employer Name:						

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

D. ASSIGNMENT OF BENEFITS AND CHARGES

Please sign below to authorize Behavior Intervention Services' Financial Department the right to submit claims to the Department of Mental Health, First Steps and or your private insurance directly. DMH or your private insurance will pay benefits directly to Behavior Intervention Services and all additional balances owed by the party receiving funding will be billed to you. You, the guardian/financially responsible party, are acknowledging your financial responsibility for all overages or non-authorized services provided beyond the DMH, First Steps or Insurance funding coverage, co-payments, co-insurance, deductibles, and/or any expense associated with the collection of a debt owed (i.e. attorney fees, court costs or collection agency fees).

Guardian/Financially Responsible Signature: _____ Date of Signature:_____

By checking the boxes below, I am indicating my agreement, and will include my signature at the bottom to agree to the items indicated.

❑ **Service Agreement Acknowledgement**

_____ agrees and consents to participate in the behavioral healthcare services offered by Behavior Intervention Services, LLC, a behavioral healthcare provider. I understand and I am consenting and agreeing only to those services the above-named provider is qualified to perform within the scope of the provider's license, certification and training, or the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the client. I attest that I have

legal custody of the above-named individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual. I have reviewed the Behavior Intervention Services policies outlined above and have had the opportunity to ask questions. By initialing beside each listed policy, I am acknowledging that I am in agreement with those policies and understand that I may update my information at any time with a BIS Service Provider or administrative representative.

Picture and Video Use

❑ I accept use of picture and video

❑ I decline use of picture and video

Behavior Intervention Services, LLC is interested in using your sons/daughter's name, photo, and/or video for use in our brochures, newsletters, website, training material, and for the creation of resumes and other material for personal client use. BIS may use photographs and video for advertisement, training, agency newspaper, branding, etc. with client consent **only**.

All Behavior Intervention Services employees have been trained on HIPAA confidentiality laws and have signed documentation agreeing to keep all client information confidential. All applicants and/or individuals not employed with Behavior Intervention Services will be required to sign a confidentiality agreement form before viewing any video which includes a client of BIS.

You have the right to view any video or photograph of your son/daughter prior to its use. You have the right to refuse the use of any video you wish not to be viewed by others.

We will keep the consent form on file for the duration of client services. Should you wish to change the consent given, please contact the office to update your file.

Research Information

I am willing for BIS to use general data information (behavior data, testing etc.) that would not violate my child's HIPAA rights for the purpose of research and study.

By signing below, I indicate I have read through the forms and handbook as pertaining to the services desired, in its entirety and agree with all aspects where I have checked the box.

_____ _____ _____

Signature (parent/guardian/conservator) Print name (parent/guardian/conservator) Date

RELEASE OF INFORMATION

PERMISSION FOR INFORMATION TO BE RELEASED TO BEHAVIOR INTERVENTION SERVICES, LLC

This document is to authorize _____ to release the information specified below regarding my individual, _____ to Behavior Intervention Services, LLC.

- ❑ Current IEP and/or IFSP
- ❑ Psychological evaluations
- ❑ Educational evaluations
- ❑ Medical evaluations and any other healthcare information
- ❑ Other: _____

Permission is also given for the above-named party to discuss issues related to this case with the staff of Behavior Intervention Services, LLC. (Both parties may disclose and receive information regarding the case.)

PERMISSION FOR INFORMATION TO BE RELEASED FROM BEHAVIOR INTERVENTION SERVICES, LLC

This document is to authorize the staff of Behavior Intervention Services, LLC to release the information specified below regarding my individual, _____ to _____.

Information to be released: _____

Permission is also given for the above-named party to discuss issues related to this case with the staff of Behavior Intervention Services, LLC. (Both parties may disclose and receive information regarding the case).

_____ _____ _____

Signature (parent/guardian/conservator) Print name (parent/guardian/conservator) Date

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Medical Release

BIS clients must authorize agents, employees, and representatives of Behavior Intervention Services (hereinafter "the agency") to obtain emergency medical assistance as needed for the child.

In the event that a client or parent or guardian of said client cannot make arrangements for emergency medical attention upon the occurrence of illness or accident, an agent, representative, or employee of Behavior Intervention Services, LLC will seek emergency assistance for the child. BIS also reserves the right to contact 911 for immediate medical interventions in the event of a true emergency. Parents/Guardians are held financially responsible for all such medical services, including the cost of defense and enforcement of this indemnity agreement.

BIS staff is certified and trained to perform CPR and First Aid. The agency, its representatives, or its employees may administer simple First Aid in the event of minor injuries, and family members or doctors will be called as deemed necessary by agency personnel.

BIS staff is not authorized to give client medication unless they are Medication Administration Level One certified and a Medication Administration Report (MAR) and Physician Orders for the medication(s) are present in the home. Only those individuals who can understand the side effects of the medications they are consuming should self-administer medications. Should you wish to have BIS staff administer medication, please speak with the Clinic Coordinator for further information.

By signing below, I indicate I have read this document in its entirety and agree with BIS policy

_____	_____	_____
Signature (parent/guardian)	Print name (parent/guardian)	Date
_____	_____	_____
Signature (parent/guardian)	Print name (parent/guardian)	Date

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Outside Permission Form Waiver

I _____, the parent of _____ ("my child"), give permission for my child to leave the BIS building to engage in outdoor activities*. This includes in the parking lot, sidewalk, front lawn and garden area at BIS (2644 Metro Blvd, Maryland Heights, MO 63043).*

I hereby release ***Behavior Intervention services***, its employees, agents and volunteers, from any and all liability, claims, demands, causes of action and possible causes of action whatsoever arising out of or related to any loss, damage or injury that may be sustained by my child while participating in these events.

If your child requires sunblock to be outdoors, please denote on this form and leave a bottle of the sunblock to be used with your child's name on it with Clinic Director, Krista Pickel.

_____ Yes, my child requires sunblock before going outdoors
_____ No, my child does not require sunblock before going outdoors

_____ I do not want my child to go outdoors or participate in any outdoor activities at BIS.

I agree and consent to all of the above stated.

_____ _____
(Parent Signature) (Date)

_____
(Print name)

_____ _____
(BIS representative Signature) (Date)

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Before and After Care Form

Child's Name: _____

There is a $100.00 weekly cost from 7:45am to 8:00am and 4pm to 5pm. **Any private paid fees are due on Monday mornings before the start of service for the week.**
Every effort should be made to pick the child up on time. Failure to pick up a child within 10 minutes of any shift end will result in $1.00 charges per minute. **Late fees are due by the following week on Monday**. If late fees are not paid in addition to the $100.00 weekly cost, then before and after care will not be permitted until all fees are paid for.

Please notify BIS a week prior to before and after care time changes as we need to schedule staffing accordingly.

During this time of before and after care, behavior analytic services will not be given or billed to insurance.

By signing below, I indicate that I have read this document in its entirety and agree with BIS policy.

_____	_____	_____
Print name (parent/guardian)	Signature (parent/guardian)	Date

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Get To Know My Child

Child's Name: _____

Things I **like**:	**Dislikes:**

My **strengths**: _____

_____

_____

My **weaknesses**: _____

_____

_____

Allergies: _____

Preferred Food	**Non-Preferred Foods**

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