THE
BEHAVIOR HELPER
ENRICHMENT CENTER
*unlock the potential*

# INTAKE PACKET

Welcome to The Behavior Helper Enrichment Center!

We are excited to have you as part of our client family and look forward to working together. Our team is committed to providing you with the highest level of service and making sure your experience is seamless and successful.

To get started, we've put together a **New Client Checklist** to ensure we have all the necessary information and that nothing is missed as we begin our journey together. Please take a moment to review and complete the checklist. This will help us serve you better and streamline the Intake process.

Your Checklist Items:

- ☐ Submit a copy of required identification card(s)
- ☐ Submit a copy of insurance card(s)
- ☐ Submit a copy of the DMH Home and Community Based Services (HCBS) Waiver Agreement
- ☐ Submit a copy of Legal Guardianship Agreement (if client is not their own)
- ☐ Submit a copy of the Individual Support Plan (ISP)
- ☐ Complete the Intake Form
- ☐ Review the Consumer Handbook
- ☐ Review Policy Acknowledgement Pages
    - Care of Client Rights Policy
    - Confidentiality Policy
    - Grievance Procedure
    - HCBS Choices and Rights
    - Notice of Privacy Practices (HIPPA)
- ☐ Sign the required documents
    - Acknowledgement Pages Confirmation
    - Consent for Electronic Delivery and Communication
    - Consent to Bill Insurance
    - Consent to Transport
    - Photography, Video, and Audio Authorization
    - Service Agreement

Please submit this packet within five (5) days to ensure your loved one is added to our clientele list. Prospective clients will remain on our Waitlist until all of the documents that require signature and submitted copies are received. You can return the forms in person, or via email or fax to Emily Hager, Intake Coordinator, at emilyh@thebehaviorhelper.org, 636-534-1453.

We are committed to making this process as smooth as possible and are here to support you at every step. If you need any assistance or clarification, don't hesitate to contact us at 636-493-1344.

- The Behavior Helper Executive Team

# THE BEHAVIOR HELPER ENRICHMENT CENTER INTAKE FORM

300 Water Street, Saint Charles, Missouri 63301 | 636-493-1344 (p), 636- 534- 1453 (f)

Please fill this form out in its entirety, legibly, and in black ink. Use additional paper if needed.

## CLIENT INFORMATION (if the client does not have a phone or email, please put n/a)

Client Name: _____ Date of Birth: _____ Age: _____

Address: _____ Apt/Unit:_____ City: _____ State: _____

Phone: _____ Email: _____

Is this address an ISL? ☐ YES ☐ NO If Yes, what agency manages the ISL? _____

Is the consumer their own Legal Guardian? ☐ YES ☐ NO

## LEGAL GUARDIAN(S) INFORMATION

Guardian Name 1: _____

Address (if different from client's): _____ City: _____ State: _____

Phone: _____ Email: _____

Guardian Name 2: _____

Address (if different from client's): _____ City: _____ State: _____

Phone: _____ Email: _____

## CASE MANAGER INFORMATION

Name: _____ Agency: ☐ DMH ☐ DDRB

Phone: _____ Email: _____

Which HCBS Wavier does the Client currently have?

☐ Comprehensive Waiver ☐ Community Support Waiver ☐ Partnership for Hope Waiver

Does the client have a current ISP that recommends ABA service delivery through an Adult Day Program? ☐ YES ☐ NO

*If No, please indicate the plan to ensure an ISP is developed or reconvened:*

_____

_____

_____

_____

## EMERGENCY CONTACTS (must be different from Guardian(s) and Case Manager)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

# HEALTH & MEDICAL SUMMARY

*A thorough and up-to-date health and medical summary ensures the well-being, safety, and effectiveness of care. This information helps staff provide care that aligns with the client's medical needs and minimizes the risk of adverse reactions or complications.*

Client Primary Care Physician: _____ Office Name: _____

Phone: _____ Email: _____

The designated emergency medical facility for TBH-EC is

SSM Health St. Joseph Hospital
300 1st Capitol Drive
Saint Charles, Missouri 63301

If you prefer a different emergency medical facility, please indicate:

_____

Does the client have a history of serious medical conditions (this does not include developmental disability)? ☐ YES ☐ NO
If yes, please explain:

_____
_____
_____

Does the client have a serious medical condition NOW? ☐ YES ☐ NO
If yes, please explain:

_____
_____
_____

Does the client currently have or been treated for any of the following? Please check all that apply:

| Condition | YES | NO | Condition | YES | NO | Condition | YES | NO |
|---|---|---|---|---|---|---|---|---|
| ADHD | | | Diabetes | | | Other Heath Impaired | | |
| Alcoholism | | | Down Syndrome | | | Psychosis | | |
| Anema/Circulatory Issues | | | Emotional Disturbance | | | Serious Head Injury | | |
| Anxiety | | | Epilepsy/Seizure Disorder | | | Sleep Issues | | |
| Asthma | | | Gastrointestinal Issues | | | Substance Abuse | | |
| Autism Spectrum Disorder | | | Headaches/Migraines | | | Visual Impairment | | |
| Cardiac Issues | | | Hypertension | | | Tic Disorder (e.g. Tourette) | | |
| Constipation (frequent) | | | Intellectual Disability | | | Other: | | |
| Depression | | | OCD | | | Other: | | |

Please indicate the following:

| Allergies | YES | NO | Explain "yes" answers by detailing the specific allergy and the reaction. |
|---|---|---|---|
| Animals | ☐ | ☐ | |
| Drugs | ☐ | ☐ | |
| Food | ☐ | ☐ | |
| Insect(s) | ☐ | ☐ | |
| Plants/Trees | ☐ | ☐ | |
| Other | ☐ | ☐ | |

Do any of the allergies listed require emergency medical treatment (Epinephrine Autoinjector, 911) if exposed? If 'yes', please indicate:

_____

Does the client have any restrictions from participating in regularly scheduled activities (this includes the ability to participate in physical fitness and/or outdoor activities)? ☐ YES ☐ NO If 'yes', please explain:

_____
_____
_____

Explain any specific accommodations required:

_____

Explain any psychiatric concerns or hospitalizations:

_____

Explain any chronic or recurring illnesses:

_____

Has menstruation begun? ☐ YES ☐ NO ☐ N/A If 'yes', does the client know what a cycle is? ☐ YES ☐ NO
Is menstruation normal ? ☐ YES ☐ NO Does the client require assistance with sanitary routines? ☐ YES ☐ NO

## MEDICATION INFORMATION

*This information helps staff understand any significant shifts in behavior. Having knowledge of a person's medication regimen allows staff to tailor interventions, therapies, and educational approaches to align with the individual's current physical and emotional state.*

| Name of Medication | What does it treat? | Dosage | Time(s) Given | Noticeable Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

On occasion, TBH may administer Over-The-Counter (OTC) medications on an as needed basis (PRN). Please indicate the following permissions for the following:

☐ Allergy Medication ☐ Eye Drops ☐ Ibuprofen ☐ Neosporin ☐ Tylenol ☐ NONE. I DO NOT CONSENT FOR PRN MEDICATION(S).

## MEDICAL INSURANCE INFORMATION (*Please attach a front and back copy of all medical insurance cards with this packet).*

Primary Insurance Carrier: _____ Policy Holder Name: _____

Policy Number: _____ Group Number: _____

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

Secondary Insurance Carrier: _____ Policy Holder Name: _____

Policy Number: _____ Group Number: _____

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

## SOCIAL & BEHAVIORAL FUNCTIONING

*This preliminary information will be shared with the client's Clinician.*

Are there any problem behaviors of concern? ☐ YES ☐ NO
If 'yes', please detail: _____
_____
_____
_____

Does the client currently have a Behavior Intervention Plan (BIP)? ☐ YES ☐ NO
If 'no', does the client need a BIP? ☐ YES ☐ NO

Please indicate what peer interactions typically look like:

- ☐ Problem relating to others
- ☐ Difficulty making friends
- ☐ Does not initiate interactions with peers but will engage with peers if they interact first
- ☐ Struggles with maintaining relationships with peers (i.e. fights frequently, inappropriate comments, lack of boundaries)
- ☐ Enjoys being around peers
- ☐ Initiates interactions with peers and can engage in reciprocal conversation
- ☐ Prefers to be alone

Please indicate communication capabilities:

- ☐ Vocal and easily understood
- ☐ Vocal but struggles with enunciation and pronunciation
- ☐ Partial-Vocal (has some words, but they are mostly approximations or words are not functional [scripts])
- ☐ Non-Vocal (does not have words)
- ☐ Uses an Augmentative and Alternative Communication Device (AAC)

Please list any special interests for the client (i.e. sports, hobbies, TV shows, music artists, characters, food, snacks, games)
_____
_____
_____
_____

What strengths do you recognize?
_____
_____
_____
_____

What weakness could be improved upon?
_____
_____
_____
_____

What would you like to gain from being a participant in the TBH-EC Program?
_____
_____
_____
_____

The following Acknowledgement pages are for your records.

# CARE OF CLIENT RECORDS POLICY

At TBH-EC, we hold the highest regard for the privacy, security, and accuracy of participant records. We are dedicated to upholding the following principles in the management and care of participant records:

**1. Confidentiality:** We are committed to maintaining the strictest confidentiality of client records. We understand the sensitive nature of these records and the trust our families place in us. Access to participant records is limited to authorized personnel who require this information for legitimate medical or administrative purposes.

**2. Accuracy:** We strive for the utmost accuracy and completeness of participant records. It is our responsibility to ensure that all information, including medical histories, diagnoses, treatment plans, data, and progress notes, is recorded accurately and updated promptly.

**3. Security:** Client records are stored and transmitted securely to prevent unauthorized access or disclosure. We employ state-of-the-art security measures to safeguard personal information from breaches or data theft.

**4. Compliance:** We adhere to all relevant laws and regulations governing the maintenance and disclosure of client records, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) in the United States.

**5. Participant Access:** Participants have the right to access their data and treatment plan in accordance with applicable laws and regulations. We provide clients with reasonable access to their records and guide them through the process if they wish to obtain a copy of their records.

**6. Retention and Disposal:** We maintain participant records for the duration required by applicable laws and regulations. When records are no longer needed, they are disposed of securely and in accordance with established retention schedules.

**7. Breach Notification:** In the event of a data breach or unauthorized access to patient records, we have procedures in place to promptly notify affected individuals and the appropriate authorities, as required by law.

**8. Continuous Improvement:** We are committed to ongoing education and training for our staff to stay current with best practices and emerging technologies related to patient record management.

By adhering to these principles, TBH-EC ensures that participant records are handled with the utmost care and professionalism. We take our responsibility seriously and will continue to uphold these standards to maintain the trust and confidence of our families.

# CONFIDENTIALITY POLICY

The Behavior Helper encounters certain information that may be considered confidential, sensitive and/or personal in nature.

In order to ensure the protection of such information, and in accordance with several State and Federal Laws, HIPAA (Health Insurance Portability and Accountability Act, FERPA (Family Education Rights and Privacy, and FACT (The Privacy Act, Gramm/Leach/Bliley and ID Theft Laws) which govern the management, dissemination and control of confidential and personal information, The Behavior Helper has established a Confidentiality Policy to be given to employees, newly hired/appointed and reviewed on an annual basis.

Should The Behavior Helper need to amend the Confidentiality Policy for any reason, a copy of the new policy will be given to and signed for by each employee. The information encountered by an employee could be relating to The Behavior Helper, and may include data about clients, applicants, business and technical information, costs, profit and margin information, finances and financial projections, customers, marketing and current or future business plans and models, regardless of whether such information is designated as “Confidential Information” at the time of its disclosure.

In addition to the above, Confidential Information shall also include, and the employees shall have a duty to protect, other confidential and/or sensitive information which is (a) disclosed in writing and marked as confidential (or with other similar designation), and/or (b) disclosed in any other manner and identified as confidential and is also summarized and designated as confidential in a written memorandum.

Confidential information shall also include the content of personal and medical information including documentation, video, audio, or other computer-stored information from unauthorized disclosure without the consent of the individual and/or the individual’s guardian in all environments.

Employees shall use the Confidential Information only for the purpose as related by nature of their job description/position within the company.

Employees shall limit disclosure of Confidential Information within its own organization to its owner, members and/or employees having a need to know and shall not disclose Confidential Information to any third party (whether an individual, corporation or other entity) without the prior written consent of The Behavior Helper.

# GRIEVANCE PROCEDURE

It is the policy of The Behavior Helper to ensure a process for filing consumer complaints and grievances from consumers served and/or their legal representatives in order to provide guidance for receiving, considering and resolving consumer complaints and grievances filed with The Behavior Helper. All complaints and grievances shall be heard promptly, investigated appropriately, and where possible, resolved informally. No consumer served by The Behavior Helper shall be retaliated against or be denied services for filing a complaint or grievance. A review of formal complaints, grievances and appeals can give the organization valuable information to facilitate change that results in better customer service and results for the consumers served.

The consumer or their legal representative may file a complaint with regard to the services provided by The Behavior Helper, if the consumer/guardian believes their rights have been violated, abuse or neglect has taken place, and/or to voice general concerns with regard to the services being provided by The Behavior Helper.

The Behavior Helper Owner/Lead BCBA will initially review all written complaints/grievances and determine a resolution/disposition of a complaint. Complaints shall be categorized by within one of three categories:

1. Information- An informational report of dissatisfaction which may include but not limited to: violation of a DMH standard or The Behavior Helper policy, contract provision, rule or statute, a practice or service is below customary business or medical practice, lack of professionalism or quality service, etc.

2. Grievance-Consumer reporting a violation of client rights per 630.110.1.

3. Suspicion/Allegation of Abuse & Neglect-neglect, misuse of funds/property, physical abuse, sexual abuse, or verbal abuse has occurred as defined in 9 CSR 10-5.200.

## ABUSE/NEGLECT OR RIGHTS VIOLATIONS

If in initially reviewing the written complaint The Behavior Helper Owner/Lead BCBA finds evidence of abuse or neglect, or evidence of a violation of client's rights on the part of The Behavior Helper Employee in reviewing a grievance, this shall be reported immediately per the relevant state statutes/Division Directives and steps shall be taken to ensure client safety, if necessary.

Complaints with regard to human rights violations by The Behavior Helper staff may be made within this process or can be made with the Dept. of Mental Health Client Rights Monitor at:

Client Rights Monitor
Department of Mental Health
PO Box 687
Jefferson City, M 65102
800-364-9687

## DISSATISFACTION WITH SERVICES

In the case of "informational" grievances including dissatisfaction with The Behavior Helper services, the following steps shall be taken:

1. If informal efforts do not produce a satisfactory solution, a complaint with regard to the services provided by The Behavior Helper may be filed in writing by the consumer/responsible party by completion of a The Behavior Helper Complaint/Grievance Form. In all cases, review actions taken and documentation made will remain

confidential.

2. Complainant shall be informed in writing within three (3) business days that the formal complaint has been received and is being reviewed. The initial review of complaints shall be completed by The Behavior Helper Owner/Lead BCBA. In addition to completing the form, complainants have the right to present any additional information they feel to be pertinent to the complaint in a meeting with The Behavior Helper. Before considering filing a complaint, it is encouraged that the complainant tries to resolve the matter informally by discussing it first with The Behavior Helper.

3. Within seven (7) working days after the complaint is filed, The Behavior Helper Owner/Lead BCBAwill submit his findings to The Behavior Helper. A letter confirming/not confirming the allegations will be sent to the consumer and/or their legal representative and The Behavior Helper staff alleged to have been involved. If the letter confirms the allegation(s), further actions will be outlined in the letter.

4. If the complainant disagrees with The Behavior Helper Owner/Lead's disposition of the complaint, they can appeal to The Behavior Helper, who will have 10 working days in which to make a decision with regard to the complaint. In this decision, The Behavior Helper may accept, reject or modify the The Behavior Helper Owner/Lead's initial recommendation, or s/he may return the case to The Behavior Helper Owner/Lead's for further proceedings.

5. The Behavior Helper shall specify the matters to be addressed in the further proceedings and shall specify the period within which those proceedings shall be conducted, not to exceed ten (10) working days.

6. The Behavior Helper decision shall be final.

7. The complainant may also file a grievance with the Dept. of Mental Health/[RO]Regional Office if s/he is not satisfied with the outcome/disposition of the complaint decision rendered by The Behavior Helper.

8. Obstruction of a complaint investigation or retaliation of any kind on behalf of The Behavior Helper staff involved shall be reported to The Behavior Helper. Obstruction of a complaint may result in indiscipline, including dismissal.

The Behavior Helper shall annually review all formal complaints that have been filed with the agency in an effort to identify trends and areas of needed improvements and develop a Plan of Action to mitigate such complaints.

The Behavior Helper prominently displays at each service site a Client Rights poster that provides the name, mailing address and phone numbers to whom grievances/complaints may be addressed.

REFERENCES:
- CARF Standards Manual, Sections 1A & 1D
- 9 CSR 10-5.200 (MO Code of State Regulations)
- 9 CSR 45-3.030 (MO Code of State Regulations)
- RSMo 630.110.1. (Revised MO Statutes)

# HOME & COMMUNITY BASED SUPPORT
# CHOICES & RIGHTS

The Behavior Helper ensures that people with disabilities have full access to and enjoy the benefits of community living through long term services and supports in the most integrated settings of their choosing.

The Behavior Helper Participant Policies verify HCBS requirements are met of the 42 CFR 441.301 Federal HCBS Rule that was effective March 14, 2014.

## ACCESS TO THE COMMUNITY (42 CFR 441.301(4)(i))

The Behavior Helper will ensure that all participants know about their community and are supported in making choices related to accessing the community including accessing services provided at local businesses, recreational opportunities, types of transportation services available, local events and activities, churches, service/civic organizations, etc. Participants shall be supported In fully accessing and becoming a member of their community. For instance, if a participant wants to attend an event, staff will assist the participant in identifying what is needed for them to participate (money, transportation, assistance of staff/natural supports, accessibility of location, etc.) and help the participant to plan and make decisions regarding natural support options and availability of funds. The Behavior Helper will support participants in researching their community to identify how to find services, local events, groups, transportation routes, etc. and help identify options for participants to choose between. Participants will be encouraged and supported in becoming a contributing member of their community.

## COMMUNITY RESOURCES (42 CFR 441.30(4)(i))

The Behavior Helper will help educate participants to seek their input on choices regarding their needs being met and accessing services in their community such as medical, behavioral, social, and recreational activities. The Behavior Helper will encourage participants to make informed choices about where they get their services.

## EMPLOYMENT (42 CFR 441.30(4)(i))

The Behavior Helper will ensure that all participants who wish to work are supported in doing so. Participants who are interested in beginning the process should talk with The Behavior Helper or request a planning team meeting to discuss employment options. The Behavior Helper will assist and/or engage in conversations with the planning team about employment service options. If participants obtain or have a job, The Behavior Helper will support them, as needed, to accommodate their identified needs and help in their success.

## CHOICE OF SETTINGS (42 CFR 441.30(4)(ii))

The Behavior Helper will help educate participants, seek their input, and discuss their preferences in activities, living arrangements, staff and if participants convey they want services at other locations. The Behavior Helper will assist and promote integration as participants without disabilities regarding living, learning, working, and enjoying life as others do in the community. The Behavior Helper educates participants on how to change their services and express their concerns or ask questions regarding the services they receive.

## HOUSING OPPORTUNITIES (42 CFR 441.30(4)(ii))

The Behavior Helper will help educate participants who have the desire to live in the least restrictive environment.

## PRIVACY (42 CFR 441.30(4)(ii))

Participants have a right to privacy. Staff will always knock before entering the bathroom where a participant is. Extra effort will be made to ensure privacy in bathrooms except when assistance is needed and documented in the ISP.

## CODE OF CONDUCT (42 CFR 441.30(4)(ii))

The Behavior Helper and staff recognize the importance of treating participants with "dignity and respect". The following code of conduct applies to anyone employed by The Behavior Helper:

1. Protect Health & Safety. If The Behavior Helper suspects a participant has experienced any abuse, neglect, exploitation, or maltreatment, our first duty is to protect the participant's health and safety. Staff must follow agency policy and criteria for reporting events.
2. Compliance with laws. All staff will conduct business activities in compliance with all applicable laws and The Behavior Helper's policies. All staff are expected to take appropriate action against co-workers who violate laws or policies.

## GRIEVANCES (42 CFR 441.30(4)(iii))

Participants can talk to staff any time they are unhappy with staff, or the services provided, and The Behavior Helper will try to resolve the issue. The Behavior Helper staff will help the participant contact their guardian or case manager if needed. If the issues have not been resolved, participants or guardians can file a written grievance, which is a formal way of telling The Behavior Helper staff that you are unhappy about something and asking for someone to help.

## FREEDOM OF CHOICE (42 CFR 441.30(4)(iv))

The Behavior Helper will educate participants in the independent choices they make, their daily activities, how they spend their time, and with whom they interact. The Behavior Helper will offer different options to participants so they may make decisions independently or with a guardian, without any due influence, based on sufficient experience and knowledge, including exposure, awareness, interactions, and/or instructional opportunities. This ensures that the choice is made with adequate awareness of all the available alternatives and consequences.

## SERVICES AND SUPPORTS (42 CFR 441.30(4)(v))

The Behavior Helper will seek input on the participant's preferences in staff and available supports. If multiple participants and guardians request a small number of staff, The Behavior Helper ensures participants have fair access to their preferred staff as available or appropriate.

# NOTICE OF PRIVACY PRACTICES (HIPPA)

(Pertaining to Written, Electronic, and Vocal Patient Information)

TBH-EC collects private and/or potentially sensitive medical information about each participant and/or the participant's family. This information is called "Protected Health Information" (PHI). PHI is information about a client and/or their family that describes demographic information, past, present, or future physical or mental health conditions and/or previous or current related health or behavioral services. TBH-EC is required by state and federal law, including the Health Insurance Portability and Accountability Act (HIPPA), to protect an individual's PHI and other personal information. This notice explains how TBH-EC may use and disclose PHI to carry out treatment, insurance authorizations, or other pertinent purposes that are permitted or required by law. It also describes family's rights to access and control PHI.

TBH-EC is required by law to abide by the terms set forth in this notice. TBH-EC reserves the right to change this notice and make new provisions at any time. If the information set forth in this notice changes, a revised Notice of Privacy Practices will be provided to parents/guardians. Parents/Guardians may also access the current version in our waiting room. PHI will not be used or disclosed without the written authorization, except as described in this notice. In addition, parents/guardians have the right to:

1. **Receive a copy of the Notice of Privacy Practices from TBH-EC upon enrollment or request.**

2. **Request restrictions on the use and disclosure of PHI.** The request must be made in writing and state the specific restrictions requested and to whom the restriction applies.

3. **Request to receive communications of PHI in confidence**.

4. **Inspect and obtain a copy of PHI contained in TBH-EC records.** TBH-EC maintains electronic records. Parents/Guardians also have the right to forward a copy of electronic information to a third party.

5. **Request an amendment or addendum to PHI if it is suspected that the PHI given to TBH-EC is incorrect, or incomplete.** Parents/Guardians must make addendum requests in writing. In the case of claims that PHI is incorrect, incomplete, or if the information was not created by TBH-EC, the company may deny the request. If a request is denied, TBH-EC will provide a written explanation within sixty (60) days of the request. In any event, any agreed upon amendment or addendum will be included as an addition to, and not a replacement of already existing records.

6. **Request an accounting of disclosures.** This right applies to disclosures for purposes other than treatment, insurance authorizations, or other purposes consistent with law. It excludes disclosures we may have made if prior authorization included the release of information to family members or friends for notification purposes, for medical emergencies, to law enforcement or detention facilities as part of a limited data set. To request an accounting of disclosure, a written letter must be submitted.

7. **Receive notice of a breach.** TBH-EC is committed to safeguarding PHI. If a breach of a participant's PHI occurs, TBH-EC will notify families in accordance with state and federal law.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

PHI may be used and disclosed by a clinician, administrative staff and others who are involved in the direct care of a participant. PHI may also be used and disclosed for insurance authorizations or to support the operation of TBH-EC's practice.

The following are examples of the types and uses and disclosures of PHI that TBH-EC is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made. All references to "you" or "your" refer to both the parent/guardian and participant receiving services through TBH-EC.

TBH-EC may use and/or disclose your clinical information for the following purposes:

**Treatment.** We may use and disclose PHI in the provision, coordination, or management of a participant's treatment plan, including consultations between healthcare providers or other personnel who are involved in the participant's care and need the information for continuity.

**Payment.** TBH-EC may use and disclose PHI to your insurance company so that we may bill and receive payment for services rendered.

**Healthcare.** TBH-EC may use and disclose PHI to healthcare providers (e.g. doctors, nurses, residents, EMTs) to ensure participants receive proper care in medical situations or emergencies.

**Operations**. TBH-EC may use and disclose PHI to support functions of our practice related to treatment, payment, quality assurance activities, case management, receiving and responding to grievances, compliance programs, audits, business planning, development, management, and administrative responsibilities.

**Treatment Alternatives**. TBH-EC may use and disclose PHI to tell parents/guardians about treatment alternatives or additional services that may be of interest or beneficial for a participant.

**Third Parties.** We may use and disclose PHI to a person, not affiliated with TBH-EC, who is directly involved with their day-to-day care. Examples include classroom teachers, social workers, related service providers or previous clinicians. We will only disclose necessary information that directly pertains to a specific objective provided a Release of Information form has been submitted.

**Research.** Under certain circumstances, we may use and disclose PHI to compare participants who received one treatment to those who receive another treatment for the same condition. There may be instances where this research is conducted by a Third Party. TBH-EC will always obtain written authorization before sharing a participant's PHI with a Third Party researcher. Under limited circumstances, TBH-EC may use and disclose PHI for research purposes without permission. Before TBH-EC uses or discloses PHI for research, without family permission, the project will go through a special approval process to ensure that conducted research poses minimal risk to the participant's privacy. All identifying information will be redacted. Researchers may contact you to see if you are interested in or eligible for participation in a formal study.

*Special Circumstances:*

**Law Enforcement, Lawsuits and Disputes.** TBH-EC will disclose PHI when required to do so by international, federal, state, or local law enforcement entities. This includes disclosing PHI about you in response to a court or administrative proceeding when a judge ordered subpoena was received, to identify or locate a suspect, fugitive, or missing person. TBH-EC will make every effort to ensure that law enforcement maintains the integrity of information received.

**Business Associates.** We may disclose PHI to individuals contracted to provide business services on behalf of TBH-EC. Examples include our third party billing agency and clinical software company. When these services are contracted, we may disclose some or all PHI so that the associate can fulfill their responsibilities. To protect PHI, we require all business associates to appropriately safeguard participant information.

**Workers' Compensation.** We may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Abuse or Neglect.** We may disclose PHI to notify the appropriate government authority if we suspect a participant has been the victim of abuse or neglect. We will only make this disclosure when required or authorized by law.

**Public Health Risks.** TBH-EC may disclose PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. Such instances generally include disclosures to prevent or control communicable diseases, injury or disability or report reactions to medications, food, or other agents.

**Serious Threats.** As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of the participant or another individual in the clinic.

**CHANGES TO THIS NOTICE OF PRIVACY PRACTICES**

TBH-EC reserves the right to change this Notice of Privacy Practices and make the new Notice of Privacy Practices apply to PHI TBH-EC already has as well as any information TBH-EC receives in the future. TBH-EC will keep this notice in the front lobby of the clinic. This notice contains the effective date on the first page, in the top right hand corner. Families will be sent information regarding changes via e-mail. If a new Notice of Privacy Practices is released, families will be asked to sign off on the new policy at the participant's next scheduled session.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the TBH-EC Director, Jessica Jones (jessica@thebehaviorhelper.org). All complaints must be made in writing with detailed information surrounding the grievance. Families may also contact the Secretary of the Missouri Department of Mental Health, or the Director of Office of Civil Rights of the U.S. Department of Health and Human Services. Families will not be penalized or retaliated against for filing a complaint.

U.S. Department of Health and Human Services
200 Independence Avenue Southwest
Washington D.C., 20201
(202) 619-0257 OR 877-696-6775

The following pages require signature and must be returned to The Behavior Helper before being added to the official Client List, which allows services to begin.

To guarantee placement on the Client List, we kindly ask that these forms be submitted within five (5) business days of receipt.

# ACKNOWLEGEMENT PAGES CONFIRMATION

I hereby confirm that I have received the following policies for The Behavior Helper (please check all that apply):

- ☐ Consumer Handbook
- ☐ Care of Client Rights
- ☐ Confidentiality
- ☐ Grievance Procedure
- ☐ Home and Community Based Services (HCBS) Choices and Rights
- ☐ Notice of Privacy Practices (HIPPA)

I further acknowledge that I have read and fully understand the contents of all the aforementioned documents, including all terms, conditions, and obligations outlined within. By signing below, I confirm my understanding and acceptance of the information provided.

_____

CLIENT PRINTED NAME

_____ _____

CLIENT SIGNATURE (ONLY IF CLIENT IS THEIR OWN GUARDIAN) DATE

_____

LEGAL GUARDIAN PRINTED NAME

_____ _____

LEGAL GUARDIAN SIGNATURE DATE

# CONSENT FOR ELECTRONIC DELIVERY & COMMUNICATION

I hereby consent to receive all communications, notices, disclosures, and other information (collectively, "Communications") electronically from The Behavior Helper (TBH-EC). This includes, but is not limited to, notifications, alerts, newsletter, Progress Notes, policies and policy changes, and any other documents that TBH-EC is required to provide.

I understand that electronic Communications may be sent via email, SMS, or through the Company's secure online platform. These Communications may contain important and legally binding information.

By providing my consent:

1. I acknowledge that I have the necessary hardware and software to access and retain electronic Communications.

2. I understand that I have the right to withdraw my consent to receive electronic Communications at any time by contacting the Intake and Communications Coordinator, Dr. Emily Hager, for TBH-EC (emily@thebehaviorhelper.org).

3. I agree to promptly update TBH-EC with any changes to including physical address, email address, phone number, insurance information, diagnosis, and medication changes.

4. I understand that withdrawing my consent may result in TBH-EC being unable to provide certain services or information electronically.

I understand that my consent to receive electronic Communications is voluntary and that I may request paper copies of Communications if desired, subject to any applicable fees.

Please note that my electronic signature below signifies my consent to receive electronic communications from TBH-EC.

_____

CLIENT PRINTED NAME

_____ _____

CLIENT SIGNATURE (ONLY IF CLIENT IS THEIR OWN GUARDIAN) DATE

_____

LEGAL GUARDIAN PRINTED NAME

_____ _____

LEGAL GUARDIAN SIGNATURE DATE

# CONSENT TO BILL INSURANCE

I hereby authorize The Behavior Helper to bill my health insurance provider for services rendered on my behalf. I understand and agree to the following:

1. Authorization to Release Information: I authorize The Behavior Helper to release any necessary medical information to my insurance provider for the purpose of billing and processing claims related to treatment.

2. Assignment of Benefits: I assign all health insurance benefits directly to The Behavior Helper for services provided. I understand that I am financially responsible for any portion of the bill not covered by my insurance, including co-pays, deductibles, and non-covered services.

3. Financial Responsibility: I acknowledge that any fees not covered by my insurance will be my personal responsibility. I agree to pay any outstanding balances according to the terms of The Behavior Helper's billing policy.

4. Insurance Coverage: I understand that it is my responsibility to provide accurate and updated insurance information. I also acknowledge that coverage for services rendered may be subject to the terms and limitations of my health insurance policy.

By signing below, I consent to the billing of my insurance for the services provided, and I agree to cooperate with The Behavior Helper to resolve any issues related to insurance claims.

_____

CLIENT PRINTED NAME

_____ _____

CLIENT SIGNATURE (ONLY IF CLIENT IS THEIR OWN GUARDIAN) DATE

_____

LEGAL GUARDIAN PRINTED NAME

_____ _____

LEGAL GUARDIAN SIGNATURE DATE

# CONSENT TO TRANSPORT

I hereby give my consent for The Behavior Helper, its authorized staff, or representatives, to transport me in a company-owned, leased, or rented vehicle for the purpose of attending appointments, activities, or events as arranged by The Behavior Helper.

I understand and agree to the following terms:

1. Authorization for Transportation: I authorize The Behavior Helper to transport me to and from designated locations in a staff-operated vehicle. I acknowledge that such transportation is provided as part of the services rendered by the company.

2. Release of Liability: I understand that while The Behavior Helper will take every reasonable precaution to ensure my safety during transportation, I release and hold harmless The Behavior Helper, its staff, and agents from any liability for injuries, losses, or damages arising from my participation in the transportation, except where negligence or intentional harm is proven.

3. Compliance with Safety Instructions: I agree to follow all instructions provided by the driver or staff member during transportation and to adhere to all safety guidelines, including the use of seatbelts and other safety measures.

4. Insurance Coverage: I understand that The Behavior Helper carries insurance for its vehicles and that in the event of an accident or injury, claims for damages will be handled according to the terms of the company's insurance policy. I also understand that my personal insurance, if applicable, may not cover incidents during transportation in a company vehicle.

5. Emergency Medical Treatment: In the event of a medical emergency during transportation, I authorize The Behavior Helper to seek necessary medical treatment on my behalf. I agree that all costs related to such treatment are my responsibility or will be billed to my insurance.

6. Voluntary Participation: I understand that my participation in transportation provided by The Behavior Helper is voluntary, and I may opt-out at any time. I am aware that alternative transportation arrangements will be my responsibility if I choose not to use company-provided transportation.

_____

CLIENT PRINTED NAME

_____ _____

CLIENT SIGNATURE (ONLY IF CLIENT IS THEIR OWN GUARDIAN) DATE

_____

LEGAL GUARDIAN PRINTED NAME

_____ _____

LEGAL GUARDIAN SIGNATURE DATE

# PHOTOGRAPHY, VIDEO, & AUDIO AUTHORIZATION

The Behavior Helper (TBH-EC) may collect video data of participants. These videos may be used to track and monitor progress for each client, and track and monitor center operations. TBH-EC may take photographs of participants and staff. Such videos and photographs may be used for TBH-EC marketing purposes.

In no instance will any participant or staff be identified, videoed, or photographed in any manner that would be considered a breach of their individual right to privacy or that would otherwise embarrass or subject them to ridicule. Staff are NOT permitted to post pictures or audio of TBH-EC clients on their personal social media pages.

Photographing and videotaping by non-TBH-EC employees are not permitted in any TBH-EC facility for reasons of privacy and confidentiality. The only exception to this policy is during special events, such as parties, graduations, and field trips where parents may wish to take pictures of their child.

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I give authorization to TBH-EC to obtain and utilize images or audio of client as identified below. I understand these images may be taken by an agency owned camera, disposable camera, or a staff or contract professional's personal device. This release will expire one year from the date of my signature or upon written notice to the Intake and Communications Coordinator, Dr. Emily Hager.

**Permissions**

Please mark your consent by putting a check mark in the appropriate box.

| Photo/Video/Audio Purpose | YES | NO |
|---|---|---|
| PHOTO- Staff Training | | |
| PHOTO- TBH-EC Marketing Materials | | |
| PHOTO- Sharing with Parent/Guardian | | |
| VIDEO- Staff Training | | |
| VIDEO- TBH-EC Marketing Materials | | |
| VIDEO- Sharing with Parent/Guardian | | |
| AUDIO- Staff Training | | |
| AUDIO- TBH-EC Marketing Materials | | |
| AUDIO- Sharing with Parent/Guardian | | |

**Please initial each statement as evidence of understanding.**

_____ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain support and services from TBH-EC.

_____ I understand that I may withdraw my consent at any time by providing a written notice to TBH-EC. I understand also that such withdrawal of my authorization may not be effective to prevent disclosure of information previously authorized or to stop previous action that has been taken in reliance on this authorization.

_____ My signature means that I have read this form or have had it read to me and explained in language that I can understand. I know what information will be disclosed and give my voluntary consent to its release.

_____ My signature means that I have the legal authorization to sign for the identified participant.

_____ My signature confirms that I am the legal parent/guardian for the identified participant.

_____
CLIENT PRINTED NAME

_____ _____
CLIENT SIGNATURE (ONLY IF CLIENT IS THEIR OWN GUARDIAN) DATE

_____
LEGAL GUARDIAN PRINTED NAME

_____ _____
LEGAL GUARDIAN SIGNATURE DATE

# SERVICE AGREEMENT

I understand that services provided by The Behavior Helper are based on an Applied Behavior Analysis (ABA) model and will be provided by a professional trained in ABA. I understand that state laws may require confidentiality be broken under certain circumstances, specifically, if I am judged by the behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected abuse.

I understand The Behavior Helper specializes in the evaluation and treatment of problem behaviors and skill acquisition. If The Behavior Helper is unable to meet my particular needs, I will be referred to an appropriate agency or individual.

I understand The Behavior Helper employs Practicum Students who are pursuing their BCBA credentials. These students are Master/Specialist level students and are used to help supervise RBTs under the strict supervision of a credentialed Board Certified Behavior Analyst (BCBA). I understand I will only have one student at a time, and this student will be dedicated to me. I understand this student may conduct assessments and take data to use confidentially for classes. I will not be unidentifiable in age, gender, name, location, etc. in any report written for an assignment. I also understand I have the right to revoke this consent at any time.

I have had all questions relayed and answered. I also understand that I have the right to discontinue services/withdraw consent for services with The Behavior Helper at any time.

I fully and freely give my consent for services to be implemented by The Behavior Helper during the following days and times:

- ☐ Monday Full Day (9:00a- 3:00p)
- ☐ Monday Part Time _____ (please specify the time)
- ☐ Tuesday Full Day (9:00a- 3:00p)
- ☐ Tuesday Part Time _____ (please specify the time)
- ☐ Wednesday Full Day (9:00a- 3:00p)
- ☐ Wednesday Part Time _____ (please specify the time)
- ☐ Thursday Full Day (9:00a- 3:00p)
- ☐ Thursday Part Time _____ (please specify the time)
- ☐ Friday Full Day (9:00a- 3:00p)
- ☐ Friday Part Time _____ (please specify the time)

_____

CLIENT PRINTED NAME

_____ _____

CLIENT SIGNATURE (ONLY IF CLIENT IS THEIR OWN GUARDIAN) DATE

_____

LEGAL GUARDIAN PRINTED NAME

_____ _____

LEGAL GUARDIAN SIGNATURE DATE