LITTLE STARS
THERAPY SERVICES

INFORMED CONSENT FOR BEHAVIORAL SERVICES

I hereby voluntarily apply for and consent to services by Little Stars Therapy Services, LLC. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed as follows: (1) Where abuse or harmful neglect of children, the elderly, or disabled or incompetent individuals is known or reasonably suspected; (2) Where such information is necessary for the company to pursue payment for services rendered; (3) Where an immediate threat of physical violence against a readily identifiable victim is disclosed to the therapist; (4) Where the client is examined pursuant to a court order. I hold Little Stars Therapy Services, LLC harmless for releasing information under the above conditions.

_____ _____

Signature Date

_____ _____

Printed Name Name of Client

INFORMED CONSENT TO BILL FOR SERVICES

_____(initials) If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with Little Stars Therapy Services billing policy;

_____(initials) If my insurance is accepted, I authorize payment of benefits to Little Stars Therapy Services or will reimburse Little Stars Therapy Services if I am paid directly by my carrier;

_____(initials) I hereby authorize that Little Stars Therapy Services may furnish information concerning my child and his/her diagnosis and treatment to my insurance carrier(s) in accordance with its privacy policy;

_____(Initials) I am advised that any services that insurance does not cover will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by Little Stars Therapy Services (unless the patient has state issued Medicaid insurance which prohibits any charges be accrued by the patient);

_____ ___/___/___

Patient Signature Date

LITTLE STARS
THERAPY SERVICES

SERVICE AGREEMENT AND CONSENT FORM

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operation. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) attached to this Agreement, explain HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

SERVICES OFFERED

We will provide services specifically designed to help you (and/or your minor child), or otherwise provide you with referrals to other professionals. Our behavioral services consist primarily of individual assessments (behavioral evaluations), training, in-home and in-school consultations and observations, long-term ABA service provision to youth with ASD or other related disabilities, and short-term consultations with individuals, parents, educators, and other related professionals.

APPOINTMENTS

Except for rare emergencies, we will see you (or your child) at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitate the occasional cancelation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you speak to our staff personally to give as much notice as possible to cancel or reschedule. This will allow us to offer your time to another person. You may be charged the standard hourly rate for appointments missed or canceled with less than 12 hours advance notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

Services are best provided in the atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified

information to specific individuals, or under other conditions and as mandated by Kansas and Federal Law and our professional codes of conduct/ethics. These exceptions are discussed below.

TO PROTECT THE CLIENT OR OTHERS FROM HARM

If we have a reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, and intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

PROFESSIONAL CONSULTATIONS

Behavior Analysts routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them. We will tell clients about these consultations. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

FEES

Autism Specialist/BCBA hourly fee is $125-$150 per hour for consultations, meetings, and therapy. Assessments are typically $700. Please call for travel rates for services provided more than 40 miles from 67030.

CONTACTING US

Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends). If you are difficult to reach, please provide us with times when you will be available. Because of the nature of the services we provide, we do not provide on-call coverage 24 hours per day, 7 days a week. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep clients' PHI in one set of professional records. The clinical record includes information about reasons for seeking our professional services, the impact of any current or ongoing problems or concerns, assessments, consultative or therapeutic goals,

progress toward goals, a medical/developmental/educational/social history, treatment history, any treatment records that we receive from other providers; reports of any professional consultation; billing records; releases; any reports that have been sent to anyone, including statements for your insurance carrier. Personal notes are taken during supervision sessions and by the ABA therapist. While the contents of personal notes vary from client to client, most are antidotal notes related to progress and future goals, reference to conversations, and hypothesis of the professional. These personal notes are kept separate from the clinical records and are not available to you and cannot be sent to anyone else, including the insurance company. Your signature below waives all rights, now and in the future, to accessing these records in any form and under any circumstances. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this agreement and our policies and procedures. We are happy to discuss any of these rights with you.

CONSENT

Your signature(s) below indicate that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

_____ _____

Client or Child's Name Date

_____ _____

Parent/Guardian Name Parent/Guardian Signature

PERMISSION TO PHOTOGRAPH

LITTLE STARS
THERAPY SERVICES

I give permission and consent for Little Stars Therapy Services, LLC to photograph my child and/or myself during the time my child is enrolled in services. I understand these photographs may be used in educational training presentations.

Child's Name: _____ DOB: _____

_____ _____

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

In addition to the above, I also give permission for Little Stars Therapy Services, LLC to use full-face photographs of my child for promotional or marketing materials.

_____ _____

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

PERMISSION TO VIDEOTAPE OR AUDIOTAPE

I give permission and consent for Little Stars Therapy Services, LLC to videotape and/or audiotape my child and/or myself during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Little Stars Therapy Services, LLC and the family.

Child's Name: _____ DOB: _____

_____ _____

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

In addition to the above, I also give permission for Little Stars Therapy Services, LLC to use recorded video segments to present to parents and professionals for conferences and/or other training purposes.

_____ _____

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

LITTLE STARS
THERAPY SERVICES

PARENT GUIDELINES

Your cooperation on the following is greatly appreciated to assist us in working with your child:

1. Your child should be dressed and fed prior to therapist arrival unless these skills are being addressed in the program.
2. A parent or responsible adult (18 +) must be in the home when therapy is being provided.
3. The area being used for therapy must be a comfortable temperature and well lit.
4. The materials and reinforcers used for therapy should be left alone outside of therapy time.
5. The therapists are NOT allowed to take a child in their automobile.
6. The therapist must wait 15 minutes if the child is not there at the therapy time and then is allowed to leave. The child will be considered absent and the session will not be rescheduled. You will be charged for the session and this is not billable to insurance.
7. The telephone numbers of all therapists should be in the front of the therapy book so that parents can contact them if necessary. Please do not call the therapists before 8am or after 9pm.
8. Parents should contact a therapist 24 hours prior to an appointment if the parent knows they are going to cancel a session. If more than 25% of sessions are canceled in a 3-month period, your child may lose their therapy slot.
9. Sickness. Please notify the therapist, as much in advance as possible, if your child will not be able to participate in the program the next day. Sickness includes, but not limited to the following:
    a. Temperature above 100 degrees
    b. Mumps
    c. Pin worm
    d. Communicable disease
    e. Chicken pox
    f. Lice
    g. Vomit
    h. Diarrhea
    i. Rash
    j. Pink eye

Parents are asked to use the same guidelines used in a school—if a child is too sick to attend school, he/she is too sick to participate in his/her therapy session. Therapy will resume as soon as the child's doctor clears him/her of being contagious or the remedy is completed. If a therapist arrives at the home and the child is sick, the therapist will not be able to work with your child.

10. The therapist will call the family if they are going to be arriving more than 5 minutes late.
11. If parents cancel a session, these hours are not made up unless the therapist agrees to do so.
12. If a therapist cancels a session, these hours may be made up as soon as possible and the family will be informed as to when this is going to occur.
13. The parents cannot change therapy hours because most of the therapists in your home will be servicing other clients. If there is an occasional issue such as doctor's appointment or family

occasion, then every effort will be made to try to accommodate this. These accommodations must be made through the clinical director and the individual therapist.

14. A therapist cannot change appointment times without agreement from the family.
15. In the case of snow of inclement weather:
    a. Please listen to the radio for announcements of school closings for the district in which you reside. If the district schools are closed, it is an indication that driving in that area presents danger. Little Stars Therapy Services therapists should not report to work that day.
    b. Since schools in the district are closed on inclement weather days, the time missed on those days can be made up at the discretion of the therapist and the family.
16. In case of an accident or unusual incident, the therapist should complete a form and family and clinical director should be informed within 1 working day.
17. Parents and therapists should be respectful and courteous to each other. Open communication between parents and therapists is essential to the establishment of a successful program for the child. All communication must be done in a courteous and respectful manner. If there are any problems or concerns, please contact the clinical director immediately
18. Parents are encouraged to share with therapists any information that may be helpful in getting to know their child and will enable them to work successfully with the child.
19. Periodic videotaping of sessions may be helpful in assessing the progress of the child. Prior to videotaping, permission must be obtained by all parties involved and can be terminated at any time. Additionally, parents may request a copy of the taped session on a medium provided by them.
20. Parents must sign each therapist's timesheet to confirm the number of service hours provided at the end of each session.
21. No therapy for siblings. Little Stars Therapy Services therapists are not obligated to work with siblings. If a therapist feels a sibling can be used as a participant in a session, it is at their discretion.

I understand and agree to the parent guidelines as described above.

_____ _____

Parent/Guardian Signature