Living Learning
Enrichment Center

315 Griswold
Northville, MI 48167
248.308.3592
Intake@livingandlearningcenter.org
www.livingandlearningcenter.org

PROSPECTIVE CLIENT

SUBJECT: CLIENT SERVICES

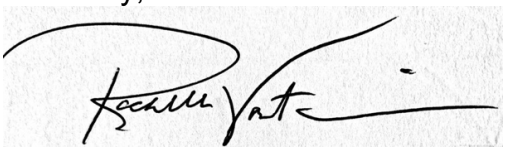
Dear Prospective Client,

Thank you for your interest in the Living and Learning Enrichment Center. Please complete the Client Registration Form to provide sufficient information to assess how we can be of service. Additionally, there is a Client Referral Form that can be completed by the client's diagnosing professional. With these two documents we can begin to assess an appropriate path towards beginning treatment.

Once you have completed the documents, you can mail them, together with a copy of your insurance card(s), front and back, to the above address or email them to intake@livingandlearningcenter.org. We are available for phone consultation at 248-308-3592 should you have any questions.

Thank you again for your interest in our services and we look forward to working with you.

Sincerely,



Rachelle Vartanian, M.Ed Psy, M.ASD
Founder & CEO

Service Requirements Checklist:

1. Pre-approval from insurance company (if applicable) is required prior to any evaluation, therapy, or other service being provided.

2. Intake
   - Assessment with Living and Learning Enrichment Center BCBA-D
     - FBA, AFLS, etc.

3. Parent Meeting –Development of treatment plan and review of reports, goals

4. Scheduling therapy sessions

5. ABA Services will be conducted by a Registered Behavior Technician (RBT) under the supervision of a Board Certified Behavior Analyst-Doctoral (BCBA-D)

6. Monthly meetings to review progress

7. Quarterly/biannual assessments to continue guiding instruction

Living and Learning Enrichment Center is happy to accept payments from several insurance companies. If you would like to explore your child's eligibility, please provide the following information.

1. Front and back of insurance cards
2. ASD Diagnosis
3. Updated/current IEP
4. Prescription from physician for ABA treatment

Living Learning
Enrichment Center

Mission: to help individuals with autism and related challenges reach their full potential in work, relationships and in the community.

Purpose: to serve this “forgotten population” of teens and adults who have autism and related challenges by offering a variety of services that will enhance their life and their families.

Vision: to be the nation’s model in creating meaningful lives for people who have autism and related challenges by providing the skills they need to be contributing members of the community.

Philosophy: The Living and Learning Enrichment Center supports evidence-based treatment methods based in the principles and procedures of Applied Behavior Analysis, including but not limited to: Peer Mediated Instruction and Intervention (PMII), Social Skills Training (SST), Video Modeling (VM), Naturalistic Interventions (NI).

A child’s program is individualized to meet his/her needs. We first assure that each client meets eligibility requirements and appropriateness for admission to treatment. We then begin treatment planning by completing initial assessments including but not limited to Functional Behavior Assessments (FBA), Preference Assessments, AFLS, ABLLS, in order to guide instruction and develop the most effective treatment plan possible for each client. Each skill area/domain contains specific curriculum designed to increase each client’s functioning and independence. Individual Treatment Plan goals will be established with the collaboration of parents, and/or the home school district, and/or other professionals that form the multidisciplinary team.

Contact Information:
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Clinical Director
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248.308.3592

An Overview of ABA Therapy

The Living and Learning Enrichment Center (LLEC) utilizes the principles of Applied Behavior Analysis and develops individualized programs or treatment plans that target cognitive, speech, language, academic or work readiness, behavior management, independence and social skills. Each individualized program is based on the client's strengths and works to decrease skill deficits.

Applied Behavior Analysis is the study of the functional relationship between one's behaviors and their environment. Data is collected on the stimuli that elicits, increases, decreases, or maintains the client's behavior. The data is analyzed and a treatment plan or an individualized ABA program is implemented. As the client's treatment progresses, data is collected and analyzed again to determine treatment effectiveness. The goal of a behavior analyst is to utilize behavioral contingencies to help the client learn more functional skills that can replace problematic behaviors and improve quality of life. LLEC seeks to produce significant results enabling the client to adapt to their environment thus preparing them for a brighter future.

Individualized Programming/Development

Each client is unique and therefore we believe it is our job to design a behavior intervention program that is individualized to your child's specific needs. Our highly skilled staff continually assess each client's needs and use researched based curriculum to create a specialized program for each child. Our staff members are trained in a wide range of ABA methods so that they have many options to find the intervention that works best to meet your client's specific needs.

Assessments

Functional Behavior Assessment (FBA) is the primary tool used to identify and attempt to understand a child's behavior. It is a multidisciplinary approach that incorporates a number of techniques, sources of information, and strategies to understand the reasons behind anti-social and/or problematic behavior and to develop strategies or interventions to address them. The process involves documenting the antecedent (what comes before the behavior), behavior itself and consequence (what happens after the behavior) over a number of weeks; interviewing parents, and others who work with the child; and manipulating the environment to see if a way can be found to prevent the behavior. This information is important because it leads the observer beyond the "symptom" (the behavior) to the student's underlying motivation to escape, "avoid," or "get" something, which is the root to all behavior. The findings from the FBA become the basis for the Behavior Intervention Plan.

Assessments continued

AFLS -The Assessment of Functional Living Skills (AFLS) is an assessment, skills tracking system, & curriculum guide for the development of essential skills for achieving independence. It can be used to demonstrate a learner's current functional skill repertoire & provide tracking info for the progressive development of these skills. The AFLS contains task analyses of the skills essential for participation in family, community, & work environments. Other assessments are completed based on the individual needs of each client.

ABLLS-R -The Assessment of Basic Language and Learning Skills -Revised is an assessment tool, curriculum guide, and skills-tracking system used to help guide the instruction of language and critical learner skills for children with autism or other developmental disabilities. The ABLLS-R contains a task analysis of the many skills necessary to communicate successfully and to learn from everyday experiences. It provides both parents and professionals with criterion-referenced information regarding a client's current skills, and provides a curriculum that can serve as a basis for the selection of short- and long-term objectives.

BIP-Behavior Intervention Plans (BIP) are developed from a Functional Behavior Assessment (FBA). Behavior Intervention Plans increase the acquisition and use of new alternative skills, decrease the problem behavior and facilitate general improvements in the quality of life of the individual, his or her family, and members of the support team.

Social Skills Training (SST)- LLEC provides social skills training to children with Autism Spectrum Disorder and other developmental disabilities. The focus of the program is to increase the child's overall ability to:

- Make social initiations
- Respond appropriately to social initiations from others
- Develop appropriate peer relationships
- Expand their interest in age appropriate topics and activities
- Increase their ability to recognize others emotions
- Minimize stress and anxiety when participating in social interaction.

Functional Communication Training (FCT) is used to teach and establish replacement behaviors for inappropriate or problematic behaviors. When a client is regularly engaging in disruptive, challenging behaviors the client if often having difficulty communicating or meeting their wants and needs. Even for a verbal child, but particularly for a non-verbal child, behavior is a way of communicating. It is our role to develop a comprehensive ABA program to replace challenging behaviors with more effective and efficient positive/functional behaviors in order to get their needs and wants meet in a more socially acceptable manner.

Professional Development Training (Parent/Caretaker/Teacher) offers a wide range of professional development trainings for parents, families and school districts in the area of Applied Behavior Analysis.

Parent Guidelines

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

- It is safest and best for children to receive medication at home. As such, LLEC does not administer medication to clients.
- If your family is planning an extended vacation (more than 2 weeks), please inform the RBT and supervisor.
- In case of an accident or unusual incident, the RBT should complete an incident form and family and supervisor will be informed within 1 working day.
- Sickness. Please notify LLEC, as much in advance as possible, at least the night, before the scheduled session if you know that your child will not be able to participate in the program the next day due to illness. Sickness includes, but not limited to the following:

    - Temperature above 100
    - Communicable Disease
    - Hand/Foot/Mouth
    - Vomiting
    - Measles, Mumps, Chicken Pox
    - Diarrhea
    - Pin Worm
    - Strep Throat
    - Lice
    - Rash
    - Pink Eye

Parents are asked to use the same guidelines used in a school –if a child is too sick to attend school, he or 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.

Parents and consultants/therapists should be respectful and courteous to each other. Open communication between parents and consultants/therapists is essential to the establishment of a successful program for the child. If there are any problems or concerns, please contact the Assistant Director or Clinical Director immediately.

Please understand that all information shared is HIPPA protected, it is essential that every LLEC employee respects and maintains each client's right to confidentiality regarding his or her treatment and all personal information.

All HIPPA laws apply. Please do not ask about another client's program or treatment, as this information will not be discussed and could possibly lead to the dismissal of your child from the program.

Parent/Guardian Initials____

Scheduling and Sessions

Except in cases of emergency, 24 hour's notice is required for all cancelled appointments. We request that families give us at least two week's notice on significant changes in their plans to facilitate consistency in service delivery. The universal standard for therapy is that the last 15 minutes of each session is devoted to data collection, note writing, material preparation/organization for the following session and discussion of session with the parent.

HIPPA 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 new privacy protections and new 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) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires we obtain your signature acknowledging we have provided you with this information. Although these documents are long and sometimes complex, it is very important you read them carefully and you ask questions regarding the procedures. When signing this document, it will also represent an agreement between our clients/caregivers and the Living and Learning Enrichment Center. You may revoke this agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed by your health insurer to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations. If you have any questions or concerns, please feel free to bring them to our attention.

Parent/Guardian Initials_____

Recording of Virtual Classes/Sessions

I give permission for virtual programming to be recorded for exclusive use in the home setting to promote generalization and further enhance social competence for participating clients. These recordings are not to be shared outside of the home setting.

Parent/Guardian Initials:

Services and Discharge

LLEC offers a full service ABA program. To determine the program needed for a client we initially complete an assessment to determine whether a client would benefit from our services. After it has been determined that our services are needed, our BCBA-D is appointed as the team leader and develops a treatment plan based on the findings of the assessment. The treatment plan includes general and specific goals with time frames for completion. The treatment plan also includes a scheduled reassessment generally six months from the time the treatment plan is developed. The treatment plan is then implemented by the BCBA-D who supervises Registered Behavior Technicians on proper implantation of the treatment plan.

As needed, the program is adjusted by the BCBA-D to accommodate the client's progress. If the treatment plan is over challenging, the plan will be modified with lower intensity goals. As the client advances through the program more challenging goals can be added to the plan. After adjusting the treatment plan and following the updated plan we may determine our services are not the proper treatment for the client.

If such a determination is made, we will follow our discharge and referral protocol. Once the client has attained the level of development similar to a typical developing individual, the client will be put on a maintenance program until the BCBA-D determines services will no longer benefit the client. Being that a sudden stop in services can be detrimental to the skills acquired, the discharge from services is done over a long period of time to achieve a smooth transition.

Appointments/Meetings

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 necessitates the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you speak to our staff personally and 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 ($50) for appointments missed or cancelled with less than 24 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 an 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 agencies.

Parent/Guardian Initials_____

Family Engagement

LLEC strives for excellence in its ABA programs and an integral component to achieve that goal is family involvement. LLEC may request that caregivers carry over the therapy being implemented and record data for specific programs as outlined in the client treatment plan. If the client/family refuses involvement in the treatment plan, as a last resort services may be suspended or terminated based on the severity of the lack of involvement.

LLEC wants to help all clients we interact with, but without client/family involvement our treatment plans will not be as effective as possible.

To Protect the Client or Others from Harm

If we have reason to suspect that a client or other minor 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. We will inform clients of these consultations.

If you want us to talk with or release specific information to other professionals with whom you are working, you will need to sign an authorization specifying what information can be released and with whom it can be shared.

Parent/Guardian Initials_____

Supervision Requirements for Private Pay Clients

BCBAs and BCBA-Ds do not require supervision.

Programs implemented by RBTs require Each RBT must obtain ongoing supervision for a minimum of 5% of the hours spent providing behavior-analytic services per month. Supervision must include at least 2 face-to-face, real-time contacts per month.

Miscellaneous Services

Additional Services are offered that may include, but not limited to, phone consultation, co-treatments, attendance of school meetings and IEPs, attendance of psychological evaluations, etc.

Cancellation and Late Fees

LLEC takes pride in hiring and providing ongoing training to all staff in order to provide our clients with the highest quality of service. When a client is unable to come to the center for their scheduled session, LLEC is still responsible for paying for the staff that was assigned to work with your child. From a business perspective, we can only maintain a portion of this expense throughout the year.

Cancellations with less than a 24 hour notification: $50 per appointment (Please refer to our cancellation policy for more details)
Change in Fee Structure: The fee structure for all services rendered through LLEC is subject to change. Clients will be made aware of such modifications 30 calendar days prior to the effective date of any changes.

Payments/Payment Options. We accept the following forms of payment: cash, credit and check.
Invoices are billed on or about the first of each month. Payment is expected by the last day of the month. If payment cannot be paid, please contact our Office Administrator at 248-308-3592 so that a payment plan can be agreed upon.

Late Payments: If we are not contacted, a $25 late fee will be assessed on the first of each month that an invoice is not paid.

Parent/Guardian Initials_____

Professional Records

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information 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; assessment, consultative, or therapeutic goals; progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Personal notes are taken during supervision sessions by the Behavior Technician. While the contents of personal notes vary from client to client, most are anecdotal notes related to progress and future goals, reference to conversations, and hypotheses of the professional. These Personal Notes are kept separate from the Clinical Record 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 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's Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting 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 you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints made about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. Living and Learning Enrichment Center will make every attempt to ensure that individuals shall have reasonable access to treatment or accommodations regardless of race, age, creed, sex, national origin, handicap or sources of payment for care. We are happy to discuss any of these rights with you.

Parent/Guardian Initials_____

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 leave your availability within the message.

In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms described above.

Client's Name _____ Date_____

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Permission to Photograph

Please sign this form to indicate your consent/permission.

Client's Name: _____DOB: _____

I give permission and consent for Living and Learning Enrichment Center to create and/or use photos and video footage recorded during therapy sessions or events at the center.

- I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain supports and services from the Living and Learning Enrichment Center.
- I understand that I may withdraw my authorization at any time by providing written notice to the Living and Learning Enrichment Center. I understand 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.

Client's Name _____ Date_____

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

CLIENT INTAKE FORM

Basic Client Information:
Today's Date _____ Client's Name_____

Date of birth _____Age_____

Phone _____ _____
(cell)
Home address _____

City_____ State_____ Zip _____

County_____

Please indicate which service(s) you are interested in at LLEC:

- ☐Music Therapy
- ☐ Art Therapy
- ☐ Social Skill Groups
- ☐ Special Interest Groups
- ☐ Job Skills
- ☐ Life Skills
- ☐ Parent Support Group
- ☐ Summer Camp

Family Information:
Mother's name_____

Father's name _____

Employer(M)_____Employer(F)_____

Phone (Home)(M)_____Phone (Home)(F)_____

Email(M)_____Email(F)_____

Parent's marital status _____Step-mother_____

Divorce date (if applicable)_____Step-father_____

Current custody arrangement _____

_____

_____

Family Information continued:
List of (full/half/step) siblings in order of age

Name	*Relationship*	*Age*	*History of illness (physical/mental)*

Non-residential adults involved with your child on a regular basis:

What community resources are you currently utilizing (e.g., support groups, social services, school-based services, or other social supports)?

FAMILY HISTORY, CULTURAL FACTORS, LEGAL ISSUES

Is there a history of medical or mental health conditions in the family? (Please answer if known and you are comfortable providing this information.)

☐ Yes ☐ No If yes, please explain:

What is your/the client's religion? (Please answer if comfortable to do so)

_____

Are there any cultural/spiritual factors that we should be aware of or that may impact services?

☐ Yes ☐ No If yes, please explain:

What is the primary language for the client/family? _____

Does your family/the client speak any other language at home?

☐ Yes ☐ No If yes, please provide specifics:

Are there any legal or custody issues that we need to be aware of or that may impact services?

☐ Yes ☐ No If yes, please explain:

Is there any other background information about the client/your family that would be useful for our team members to know?

School Information

School _____

School district _____

Current grade _____

Teacher/counselor_____

Address

_____

City_____ State _____ Zip _____

School phone #_____

Please list previous schools:

Name	*Grades*	*Years attended*

Has your child ever been evaluated for special education or a Section 504 plan?

If yes, does the child have an IEP? _____

Date of most recent review? _____

Has your child ever been retained? _____

Diagnostic Information

Please provide a copy of all diagnostic evaluation reports, including Diagnosis, Date of Diagnosis, Who provided diagnosis?

Is there a family history of developmental and/or speech delay? Yes_____ No_____

If yes, please explain:

Medical History

Pediatrician/family physician

Name_____ Phone #_____

Psychiatrist_____ Phone #_____

May we contact the physician to provide a consultation?_____

Physician Name: _____ Phone: _____

Practice name: _____

Address: _____

_____

Please select all that apply:

- ☐ADD/ADHD
- ☐Autism
- ☐Asthma
- ☐Ear Infections
- ☐Feeding/Swallowing Difficulty
- ☐Hearing Difficulties
- ☐Other. Please explain:
- ☐ Physical Trauma
- ☐ Seizures
- ☐ Skin Problems
- ☐ Vision Problems
- ☐ Wears Glasses/Contacts
- ☐ Wears Hearing Aid(s)
- ☐ Allergies

Any hospitalizations/surgeries? ☐ Yes ☐ No If yes, please explain:

Please list all current medications and dosages:

Medication	Purpose	Dosage	Date Started

Please list any allergies your child has:

Allergies	Reaction	Treatment Protocol

Is your child on a special diet? ☐ Yes ☐ No

If yes, please explain:

Has your child had his/her hearing tested? ☐ Yes ☐ No

Date of hearing test: _____

Who completed the hearing test? _____

Results: ☐ Normal ☐ Abnormal ☐ Inconclusive

Has your child had her/his vision tested? ☐ Yes ☐ No

Date of vision test: _____

Who completed the vision test? _____

Results: ☐ Normal ☐ Abnormal ☐ Inconclusive

Developmental History

Length of Pregnancy:_____Length of Labor: _____
Type of Delivery: _____ APGAR Score: _____

Please list any complications during pregnancy or delivery:

At approximately what age did your child achieve the following developmental milestones:

Sit Up Unassisted: _____
Crawl: _____
Walk: _____
Run: _____
Dress Themselves: _____
Eat w/ Utensils: _____
Drink from a cup: _____
Bladder Trained: _____
Bowel Trained: _____
Babbled: _____
Said first Words: _____
Spoke in phrases: _____

Has there been any regression in developmental skills? ☐ Yes ☐ No
If yes, please explain:

Would you say that your child is clumsy (i.e. trips/falls often)? ☐ Yes ☐ No

Does your child have trouble with fine motor skills? ☐ Yes ☐ No
If Yes, please explain:

Speech & Language

What is your child's primary method of communicating?

☐ Gestures
☐ Sign Language
☐ Single Words
☐ Speech & Language
☐ Short Phrases
☐ Sentences
☐ Picture Exchange
☐ Communication Device
☐ Other _____

How does your child make his/her needs known?

How much of your child's language do you understand?

☐10% or less ☐11-25% ☐26-50% ☐51-75% ☐76-95% ☐96-100%

How much of your child's language do unfamiliar listeners understand?

☐10% or less ☐11-25% ☐26-50% ☐51-75% ☐76-95% ☐96-100%

Behavioral History

Please list any challenging behaviors your child currently engages in:

Does your child:

Respond to his/her name?	☐ Yes ☐ No
Follow simple directions?	☐ Yes ☐ No
Label familiar objects?	☐ Yes ☐ No
Point to objects when named?	☐ Yes ☐ No
Repeat others' expressions?	☐ Yes ☐ No
Use at least 50 words consistently?	☐ Yes ☐ No
Ask Questions?	☐ Yes ☐ No
Answer Questions?	☐ Yes ☐ No

Behavior	How often does it occur?	Is there anything that you know will trigger the behavior?	Is there anything you know that will make your child stop engaging in the behavior?

Please list any self-stimulatory (or self-injurious) behaviors your child currently engages in:

Behavior	How often does it occur?	Is there anything that you know will trigger the behavior?	Is there anything you know that will make your child stop engaging in the behavior?

Please indicate the most liked and disliked items in each category below:

	Likes	Dislikes
Food		
Toys/Objects		
Activities @ Home		
Activities/Outings in the Community		
Other		

Behavioral History continued

What are your child's strengths?

What are your child's weaknesses?

Does your child participate in any extra-curricular activities? If so, please list them:

Please list your top three immediate, short-term goals for your child:

1.	
2.	
3.	

Please list your top three long term goals for your child:

1.	
2.	
3.	

Educational History
Please indicate all past/current educational and therapy providers:

Education Provider
Name of School: _____
Classroom Type: _____
Teachers Name: _____ Grade: _____
Address: _____
Phone Number: _____
Current Schedule: _____
Does your child have a 504/IEP? ☐ Yes ☐No
If so, please provide a copy of the 504/IEP

Behavioral Therapy Provider
Provider Name: _____
Contact Name: _____ Phone Number: _____
Dates of Service: _____
Schedule: _____
Reason for discontinuing: _____
Was a Psychological Evaluation conducted? ☐Yes ☐No
If so, please provide a copy of the Psychological Evaluation

Speech Therapy Provider
Provider Name: _____
Contact Name: _____Phone Number: _____
Dates of Service: _____
Schedule: _____
Reason for discontinuing: _____

Occupational Therapy Provider
Provider Name: _____
Contact Name: _____ Phone Number: _____
Dates of Service: _____
Schedule: _____
Reason for discounting: _____

Physical Therapy Provider
Provider Name: _____
Contact Name: _____Phone Number: _____
Dates of Service: _____
Schedule: _____
Reason for discontinuing: _____

Other Therapy Provider
Provider Name: _____
Contact Name: _____Phone Number: _____
Dates of Service: _____
Schedule: _____
Reason for discontinuing: _____

Living and Learning Enrichment Center
Client Registration Form

School: _____ Grade: _____

☐ Home School ☐ General Education ☐ Autistic Support
☐ Life Skills ☐ Learning Support ☐ Private School
☐ Emotional Support ☐ Speech/Language

Contact Name: _____ Phone Number: _____

Please attach the most recent copy of your child's IEP, Psychological Evaluation, FBA and/or BIP.
The above information is true to the best of my knowledge.

I authorize my insurance benefits be paid directly to Living and Learning Enrichment Center. I understand that I am financially responsible for any balance. ("Client") I understand and agree that the treatment and services provided by Living and Learning Enrichment Center (LLEC)
create a financial responsibility on the part of the Parent. Parent agrees to pay and guarantees payment in full of any and all charges for treatment or services provided or to be provided to Client by LLEC and by other providers or professional entities that may have provided services to Client through LLEC. LLEC may bill Parent's insurance carrier on Parent's behalf; however, Parent is ultimately responsible for the payment of all charges. Parent authorizes and directs his/her insurance company to issue payment for any applicable medical benefit directly to LLEC. Parent understands and agrees that he/she is responsible for any amount not covered by insurance. I also authorize Living and Learning Enrichment Center or insurance company to release any information required to process my claims and to establish service eligibility/authorizations.

_____
Client's Name DOB

_____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

Authorization to Release Information

Client Name: _____ DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the supervision of Living and Learning Enrichment Center.

I hereby authorize Living and Learning Enrichment Center to (check all that apply):
____ Exchange information with
____ Release information to
____ Obtain information from

The following Organization/Individual in regard to the above named patient:
Name of Organization/Individual: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

I hereby authorize this information to be exchanged in the following manner(s):
____ Verbal only
____ Written form only
____ Both verbal and written communication

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

☐Education records ☐ Evaluation/assessment/eligibility records ☐ Medical records
☐ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

Other: _____

This information is to be used for diagnostic, treatment planning, and continuity of care purposes only.

This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.

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

Parent/Guardian Printed Name
_____

Parent/Guardian Signature_____ Date_____

Records Released by: _____ Date Released: _____

Records Not Released: _____

Authorization to Bill Insurance

Client Name: _____ DOB: _____

I, _____, hereby give my consent for Living and Learning Enrichment Center to bill my/my child's insurance carrier for the services rendered to my child by the above-mentioned provider. In addition, I agree to pay Living and Learning Enrichment Center any deductible or uncovered charge in accordance with my health care plan.

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

Authorization to Release Medical Information to Insurance Carrier

I understand that my express consent is required to release any health care information relating to assessment and treatment. I, _____, hereby give my consent for ABA Therapy Solutions, LLC to release medical and other relevant information to our insurance carrier as required by my/our insurance carrier to process medical billings.

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

Living Learning
Enrichment Center

Financial Responsibility Form

Please fill out the following information regarding the person who is financially responsible for the client attending LLEC:

Guarantor's Name: _____ DOB: _____
Social Security Number: _____ Relation to Client:
Address: _____ _____
Phone Number: _____
Email Address: _____
Employer: _____

Would you like your invoices to be mailed or emailed to you? ☐Mail ☐E-Mail

_____

Signature of the Individual Assuming Financial Responsibility Date

Living Learning
Enrichment Center

Insurance Information

Please provide a copy of both sides of all applicable insurance cards prior to the start of initiating services at LLEC.

Primary Insurance: _____
Subscriber's Name: _____ DOB: _____
Policy ID #: _____ Group #: _____
Relation to Client: _____

Secondary Insurance: _____
Subscriber's Name: _____ DOB: _____
Policy ID #: _____ Group #: _____
Relation to Client: _____

Printed Name of Person Completing Form: _____

Signature of Person Completing Form: _____

Date Completed: _____

Our programming is covered by many insurance policies.

Please indicate maximum age for insurance coverage:

Living Learning
Enrichment Center

Emergency Contact & Permission to Pick Client Up

Please provide a list of Emergency Contacts, in the order that you would like for us to contact them, in case of an emergency.

Name: _____ Relationship to Client: _____

Phone: _____ Is this person authorized to pick up the client?
☐Yes ☐No

Alt Phone: _____

Name: _____ Relationship to Client: _____

Phone: _____ Is this person authorized to pick up the client?
☐Yes ☐No

Alt Phone: _____

Name: _____ Relationship to Client: _____

Phone: _____ Is this person authorized to pick up the client?
☐Yes ☐No

Alt Phone: _____

Name: _____ Relationship to Client: _____

Phone: _____ Is this person authorized to pick up the client?
☐Yes ☐No

Alt Phone: _____

Authorization for Automatic Health Care Payment by Credit Card

I authorize Living and Learning Enrichment Center to keep my signature on file and to charge my account for charges that are deemed Patient Responsibility.

This authorization extends to all recurring charges, co-payments, or deductibles incurred at the time of service unless another method of payment is provided at the time of service.

If the applicable fee cannot be paid by other means at the next scheduled appointment, your credit card will be charged the appropriate amount per stated policy when the monthly invoices are processed.

This authorization shall be valid for one year, or until services are concluded, or with written notice to Living and Learning Enrichment Center.

Client's Name: _____ Client's DOB: _____
Cardholder's Name: _____
Cardholder's Billing Address: _____
Credit Card Number: _____
3-Digit CVC (back of card) _____
Expiration Date: _____

_____ _____
Cardholder Signature Date signed

*Please note: Any charges that are declined will result in a $25.00 fee for processing. Cards whose expiration dates occur during the course of the year will be subject to the above fee, if not updated within 10 days of notification of expiration

Informed Consent for Treatment of Minor & Waiver of Liability

As the parent/guardian ("Parent") of _____ , a youth with autism ("Client"), I give my consent for Living and Learning Enrichment Center ("LLEC") to provide treatment and behavioral analytic services to Client. Parent specifically authorizes LLEC to provide services to Client without the supervision of the Parent.

Parent understands that students or other trainees may participate in the provision of supervised treatment or services to Client. Parents are aware that consultants, independent contractors and professionals other than LLEC may directly provide or be involved with the provision of services to Client and Parent acknowledges that such individuals or entities are not Agents or Employees of LLEC.

Parents agree that he/she will provide LLEC with up-to-date emergency contact information. In the event of an emergency, LLEC shall, at its sole discretion, contact emergency medical personnel or seek other emergency assistance, as dictated by the circumstances. Parent agrees that LLEC nor any individual employed by or contracted by LLEC, shall be held liable by Parent or Client for any reasonable action taken in response to an emergency situation.

_____ _____

Signature of Parent/Guardian Date

Confidentiality Act/Abuse Reporting Protocol

Client Name: _____ DOB: _____

I understand that all information related to the above-named client's assessment and treatment must be handled with strict confidentiality. No information related to the Client, either verbal or written, will be released to other agencies or individuals without the express written consent of the Client's legal guardian (minor), or the consent of any Client of legal age.

By law, the rules of confidentiality do not hold under the following conditions:

- ★ If abuse or neglect of a minor or disabled person is reported or suspected, the professional involved is required by law to report it to the Department of Children & Families for investigation.
- ★ If, during the course of service, an individual receives information that someone's life is in danger, that professional has the duty to warn the potential victim as well as the authorities as is fitting to the circumstances.
- ★ If Living and Learning Enrichment Center records, any sub-contractor records, or staff testimony are subpoenaed by a court order, Living and Learning Enrichment Center is required by law to produce the requested information, including an appearance in a court of law, if necessary, to answer any questions regarding the Client.

Health Insurance Portability and Accountability Act (HIPAA)
Notice of Privacy Practices

This notice describes how protected health information about a client may be used and disclosed and how the client can gain access to this information. Please review it carefully.

Living and Learning Enrichment Center (LLEC) understands we collect private and/or potentially sensitive medical information about each client and/or the client's family. We call this information "protected health information." This notice explains the client's privacy rights and addresses how LLEC may use and disclose protected health information. LLEC does not use or disclose protected health information unless permitted or required to do so by law. LLEC must adhere to laws aimed at securing the privacy of the client's protected health information. These laws are known as the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. When we do use or disclose protected health information, we will make every reasonable effort to limit its use or the level of disclosure to the minimum we deem necessary to accomplish the intended purpose. Please note that the privacy provisions articulated in this notice do not apply to health information that does not identify the client or anyone else. For more information on LLEC privacy practices, or to receive another copy of this notice, please contact:

Living and Learning Enrichment Center
315 Griswold
Northville, MI 48167
248-308-3592

Protected Health Information

Protected health information is information about the client relating to a past, present, or future mental health condition, or treatment or payment for the treatment that can be used to identify the client. This includes any information, whether oral or recorded in any form, that is created or received by LLEC. This also includes electronic information and information in any other form or medium that could identify the client. Examples of information that can identify a client include, but are not limited to the following:

Client's Name
Telephone Number
Address
DOB
Social Security Number
Service State/End Date
Diagnosis

Uses and Disclosures of Health Information for Treatment, Payment, and Health Care Operations

1. Treatment, Payment, and Health Care Operations: The following section describes different ways we use and disclose protected health information for treatment, payment, and health care operations. Not every possible use or disclosure will be noted, and there may be incidental disclosures that are a byproduct of the listed uses and disclosures.
   a. Treatment: We may use a client's protected health information to provide the client with services, and may disclose this information to any and all LLEC staff involved with the client's

treatment. Treatment includes (a) activities performed by LLEC personnel in the course of providing service to the client or in coordinating or managing the client's service with other service providers and (b) consultations with and between LLEC staff and other professionals involved in the client's treatment

b. Payment: We may use and disclose the client's protected health information so we may bill and collect payment from the client, an insurance company, or another party for services LLEC provided to the client. We may also inform the client's health plan provider of treatment we intend to administer to obtain prior approval or to determine whether the client's plan will pay for the treatment.

c. Health Care Operations: LLEC may use and disclose the client's protected health information in order to maintain necessary administrative, education, quality assurance, and business functions. For example, we may use a client's protected health information to evaluate the performance of our staff in providing treatment for the client. We may also use information about clients evaluate what additional services to offer, how we can improve efficiency, or the effectiveness of certain treatments. Additionally, we may use protected health information for review, analysis, and other teaching and learning purposes.

2. Special Circumstances: Treatment, payment, and health care operations further include the circumstances listed below.

a. Appointment Reminders: We may use and disclose the client's protected health information to contact the client as a reminder that he/she may have an appointment for treatment or services.

b. Treatment Information: We may use and disclose the client's protected health information to contact him/her about treatment information.

c. Satisfaction Surveys: We may use and disclose the client's protected health information to contact him/her about LLEC satisfaction surveys.

3. Uses and Disclosures You Can Limit

a. LLEC Client Directory

Unless the client notifies us that he/she objects, we may include certain information about him/her in LLEC Client Directory in order to respond to inquiries and disseminate information more efficiently. This directory is accessed by LLEC staff who may or may not be involved in the client's treatment.

b. General Notification

Unless the client notifies us that he/she objects, we may provide his/her protected health information to individuals such as the client's family members, caregivers, and friends, who are involved in the client's treatment or who pay for the client's treatment. We may do this if the client informs us we have their consent to do so, or if the client knows we are sharing the client's protected health information with these individuals and the client expresses no objection or makes no reasonably discernable attempt to prevent us from doing so. There may also be circumstances when we can assume, based on our professional judgment, the client would not object to disclosure of his/her protected health information. Also, if the client is not able to approve or object to disclosures, we may make disclosures to a particular individual (such as a client's family member or friend), we feel are in the client's best interests and that relate to that person's involvement in the client's care.

Other Permitted Uses and Disclosures of Health Care Information

We may use or disclose the client's health information without the client's permission in the following circumstances, subject to all applicable legal requirements and limitations:

1. Required By Law: LLEC must make any disclosures required by federal, state, or local law. These may include, but are not limited to, disclosures pertaining to: the reporting of abuse or neglect; court orders, subpoenas, warrants, or other lawful processes; identification/location of

a suspect, fugitive, witness, missing person, or crime victim; crime on our work premises; or a serious, imminent threat. Employees of LLEC are designated as Mandated Reporters.

2. Public Health Risks: We may make disclosures for public health reasons in order to prevent or control disease, injury, or disability; or to report births, deaths, disease or condition, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
3. Health Oversight Activities: We may disclose protected health information to agencies authorized to receive reports for health oversight activities for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.
4. Lawsuits, Disputes, or Other Legal Proceedings: We may make disclosures in response to a subpoena or court or administrative order, if the client is involved in a lawsuit or dispute, or in response to a court order, subpoena, warrant, summons or similar process, or if requested to do so by law enforcement.
5. Coroners, Medical Examiners, Funeral Directors, and Organ Donation: We may disclose information to a coroner or medical examiner, (as necessary, for example to identify a deceased person or determine cause of death) or to a funeral director, as necessary to allow him/her to carry out his/her activities.
6. Research: We may use or disclose protected information for research purposes under certain limited circumstances. Research projects are subject to approval by an institutional review board. Therefore, we will not use or disclose the client's protected health information for research purposes until the particular research project, for which the client's information may be used or disclosed, has been approved through the institutional review board.
7. Serious Threat to Health or Safety; Disaster Relief: We may disclose information to appropriate individual(s)/organization(s) when necessary (a) to prevent a serious threat to the client's health and safety or that of the public or another person, or (b) to notify the client's family members or persons responsible for the client in the course of a disaster relief effort. We will disclose protected health information only to persons we believe to be able to lessen/prevent the threat and will limit disclosure to that which we deem necessary to lessen or prevent the threat.
8. Military and Veterans: We must make disclosures as required by military command or other government authority for information about a member of the domestic or foreign armed forces.
9. National Security; Intelligence Activities; Protective Services: We may disclose information to federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.
10. Correctional Facilities: We may make disclosures to a correctional facility (if the client is a ward) or a law enforcement official (if the client is in that person's custody) as necessary (a) for the institution to provide the client with treatment; (b) to protect the client's or others' health and safety and the security of the correctional facility.

WHEN WRITTEN AUTHORIZATION IS REQUIRED

Other than for the range of purposes previously identified in this notice, we will not use or disclose the client's protected health information for any purpose unless the client provides us with specific written authorization to do so. If the client grants us authorization, the client can still withdraw this authorization at any time, though the authorization must be revoked in writing. In order to withdraw the authorization, the client must deliver, mail or email to:

Living and Learning Enrichment Center
315 Griswold
Northville, MI 48167
248-308-3592

If the client revokes the authorization, we will discontinue the use or disclosure of the client's protected health information to the extent that we relied on his/her authorization for the use/disclosure. However, we cannot take back or undo any use/disclosure made under the client's grant of authorization prior to our receipt of the client's written revocation of that authorization, and we must continue any use/disclosure that is necessary in keeping records of the client's treatment.

The Client's Rights Regarding the Client's Health Information

The client has certain rights regarding his/her health information, which are listed below. In each of these cases, if the client wants to exercise his/her rights, the client must do so in writing by completing a form the client can obtain from LLEC. In some cases, we may charge the client for the costs of providing materials to the client. The client can get information about how to exercise his/her rights and about any costs that we may charge for materials by contacting us.

1. Right to Inspect and Copy: With some exceptions, the client has the right to inspect and get a copy of the client's protected health information that may be used to make decisions about the client's care. We may deny the client's request to inspect and/or copy information in certain limited circumstances, and, if we do this, the client may ask that the denial decision be reviewed.
2. Right to Amend: The client has the right to amend his/her health information maintained by LLEC, or used by us to make decisions about the client. We will require that the client provide a reason for the request, and we may deny the request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment), (b) is not part of the health information we keep, (c) is of a type the client would not be permitted to inspect and copy, or (d) is already accurate and complete.
3. Right to an Accounting of Disclosures: The client has the right to request an accounting of disclosures. An accounting is a list of certain disclosures we made regarding the client's protected health information. The list does not include all disclosures. For example, it does not include disclosure to the client, disclosure for treatment, payment, and health care operations purposes described above, or disclosure made with the client's authorization as described above.
4. Right to Request Restrictions: The client has the right to request a restriction or limitation on the health information we use or disclose about the client (a) for treatment, payment, or health care operations, or (b) to someone who is involved in the client's care or the payment for it, such as a family member or friend. We are not required to agree to the client's request. Any time LLEC agrees to a restriction, it must be in writing and signed by the Chief Clinical Officer or her designee.
5. Right to Request Confidential Communications: The client has the right to request we communicate with the client about health matters in a certain method or at a certain place. For example, the client can ask that we only contact the client at home or by mail.
6. Right to a Paper Copy of This Notice: The client has the right to a paper copy of this notice, whether or not the client may have previously agreed to receive that notice electronically.
Questions and/or Complaints If the client has any questions about this notice, he/she should contact:

Living and Learning Enrichment Center
315 Griswold
Northville, MI 48167
248-308-3592

If the client believes his/her privacy rights have been violated, the client may file a complaint with LLEC using the contact information provided above. To file a complaint with the Secretary of the Department of Health and Human Services, call (877) 696-6775.

If the client believes his/her privacy rights have been violated, contact: Office of Civil Rights, Medical Privacy Complaint Division U.S. Department of Health and Human Services 200 Independence Avenue, S.W. HHH Building, Room 509H
Washington, D.C. 20201
Phone: (866) OCR-PRIV (627-7748) TTY: (886) 788-4989 www.hhs.gov/ocr
The client will not be penalized for filing a complaint and the client will continue to have the same access to LLEC.

Acknowledgement and Receipt
I acknowledge that I have received a copy of LLEC Notice of Privacy Practices. I further acknowledge that I have reviewed and understand the information presented in this notice, including the appropriate contact information for the party(ies) I should contact in the event that I have any further questions, concerns, requests, or complaints regarding any of the covered subject matter.

Client's Name: _____DOB: _____

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

_____ _____
Witness Date

I understand my rights regarding my child's Personal Health Information (PHI) and Behavioral Therapy Notes and how this information will be used, as presented in the Privacy Notice.

I consent to the use and disclosure of my/my child's PHI/Program Information for purposes of treatment, payment, or other health care operations. I understand and agree to the legally imposed required disclosures and the stated office practices, which do not require my signature for disclosure.

Other uses of my child's PHI/Program Information will require an authorization from me for the specific intention of the disclosure.

Client's Name: _____

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Safety Control Procedure Implementation and Release Plan

Client Name: _____ DOB: _____

LLEC uses the following plan for safety control procedure implementation and release, based on crisis prevention intervention strategies, as specific to this client.

Criteria for Safety Control Procedure Implementation:

When _____ displays behavior that may harm themselves or others and/or may result in significant property damage, crisis management techniques will be used as a temporary safety precaution. These techniques may involve physical restraint according to crisis prevention intervention procedures to maintain the safety of the client and of others.

All adults who work with _____ have been trained in several physical management techniques.

Criteria for Safety Control Procedure Release

Safety control procedures will be released when _____ does not engage in physical aggression, property damage/destruction for a 10 second calm count.

Crisis Management Documentation

When a crisis management technique is used, the date, time, duration, and the adults involved will be documented. If any injuries occur to _____ or to the adults working with _____, they will also be noted. Each day, the parent/guardian will be notified of the total frequency of the safety control procedures that were implemented. _____'s parents/guardians will be notified by written or verbal communication the same day that the crisis management techniques are implemented.

Parent/Guardian Approval:

I, _____, understand that if the safety control program criteria (as defined above) is met, that a safety control procedure will be implemented and released according to the release criteria (as defined above), as well as how I will be contacted regarding the occurrence of safety control procedure implementation. I understand that I can contact the Clinical Director, Mari MacFarland, at 248.308.3592, if I have any questions about this plan or would like to withdraw my consent to the procedure(s).

Parent/Guardian Signature: _____ Date: _____