Dear Client/Parents/Guardians,

Welcome to Changing Lanes Intervention Human services (CLIHS) .We greatly appreciate your interest in our services and we are looking forward to working very closely with you and your family while assisting you in achieving your goals.

Changing Lanes Intervention Human services is a highly experienced therapy group that provides individualized consultation and intervention services for individuals who are diagnosed with Autism Spectrum Disorder (ASD). Our behavior specialists utilize evidence-based therapies, such as Applied Behavior Analysis (ABA), which uses a multi-step approach to assist our clients in overcoming challenging behaviors associated with difficulties in social skills, communication and other areas of development.

The individualized therapy provided will also give our client(s) the foundation and tools that he or she needs to succeed in the future, thereby livinging their most productive lives. Our staff members and Providers are highly trained and dedicated to meet the needs of the families they serve. The first step to enroll in our program is completing the necessary paperwork for the client. *Please thoroughly fill out each page of the ABA intake packet that is provided below.* We understand that this form may be time consuming, and in some areas redundant. We want you to know that the more information that we have for our clients, the better we will be able to assist you and your family. We want this process to be as smooth as possible. If at any time you have any questions, please feel free to contact us at (770) 580-4116.

The information in this intake packet will also help inform you of Changing Lanes Intervention Human services policies and procedures and allow you time to gather information prior to your intake appointment.

Once you have completed the packet and submitted it, an intake coordinator will contact you to continue the intake process.

Thank you again for your interest in our provided services.

Changing Lanes Intervention Human services

Table of Content

PLEASE!! MAKE A COPY AND RETAIN IT FOR YOUR RECORDS.

Please include the following documents with your intake packet

- **All medical (Records) documentation including psychological and medical reports relating to all autism diagnosis and any other diagnosis that the client may have.**
- **Current or most recent Individualized Education Program (IEP) and Individualized Family Service Plan (IFSP).**
- **Recent assessments/ evaluations including Speech Therapy, Occupational Therapy and Physical Therapy.**
- **Discharge Notice/Letter (if client is currently under the care of another provider For ABA services.**

Today's Date:_____

Intake Form

Client Information

Client's Name:_____
DOB:_____ Gender:_____ SSN:_____
Address:_____
Lot/Suite/Apt #_____
City:_____ State:_____ Zip:_____
Work Number:_____ Home Number:_____
Cell Number:_____ Email Address:_____
Marital status: Married _____ Separated_____ Divorced_____ Single_____
Is one parent the Legal Guardian of the client? Yes_____ No_____ N/A_____

Insurance Information

Does the client have insurance? Yes_____ No_____

PRIMARY INSURANCE:_____ Policy Holder:_____
Policy Holder D.O.B. _____ Relationship:_____
Policy Holder Address_____
City:_____ State:_____ Zip Code:_____
Policy Number:_____ Group Number:_____

SECONDARY INSURANCE:_____Policy Holder:_____
Policy Holder D.O.B. _____ Relationship:_____
Policy Holder Address_____
City:_____ State:_____ Zip Code:_____
Policy Number:_____ Group Number:_____

Family Information

Parent/Guardian 1: Name:_____ Date of Birth:_____

Relationship to the Client:_____Occupation:_____
Address (if different from client):_____
Lot/Suite/Apt #_____
City:_____ State:_____ Zip:_____
Work Number:_____ Home Number:_____
Cell Number:_____ Email Address:_____
Marital status: Married _____ Separated_____ Divorced_____ Single_____
Preferred method of communication: Call_____ Email_____Text _____

Parent/Guardian 2: Name:_____ Date of Birth:_____

Relationship to the Client:_____Occupation:_____
Address (if different from client):_____
Lot/Suite/Apt #_____
City:_____ State:_____ Zip:_____
Work Number:_____ Home Number:_____
Cell Number:_____ Email Address:_____
Marital status: Married _____ Separated_____ Divorced_____ Single_____
Preferred method of communication: Call_____ Email_____Text _____

If yes, which parent is the Legal Guardian?_____

Please detail how custody is shared (e.g., where the client resides each day of the week):
_____
_____
_____

What is the primary language spoken by each Parent/Guardian/Client?
Parent/Guardian 1 _____ Parent/Guardian 2 _____

What is the primary language spoken by the client? _____
Was the client adopted? Yes_____ No_____
Siblings Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Is there any family history of developmental disability or mental illness? ___Yes ___No

Condition: _____Relation to client: _____
Condition: _____Relation to client: _____
Condition: _____Relation to client: _____
Condition: _____Relation to client: _____

Does the client have any allergies(if Yes please list)? Yes____ No _____

_____
_____
_____
_____
_____
_____
_____

Are there any pets in the home? Yes_____ No _____
Does anyone living in the home smoke? Yes _____ No_____

If Yes, please explain:

_____
_____
_____
_____
_____
_____

Please let us know of any Spiritual beliefs, Cultural values, Practices or Traditions that you follow. This will assist us with scheduling services and possibly determining skills to be targeted in therapy.

_____
_____
_____
_____
_____

Emergency Contacts

Name: _____Relationship to client: _____
Phone: _____
Name: _____Relationship to client: _____
Phone: _____

I _____ Agree and approve that in the case of an emergency if neither parent/ guardian can be reached, staff of Changing Lanes Intervention Human Services is granted permission to contact the emergency contacts Listed above.
If you AGREE Sign _____

School Information

School District: _____
Name of school: _____ Grade: _____
Date enrolled: _____ Date of most recent IEP: _____
Days and times of school attendance:_____
_____

Related Services- Current and past services received (e.g., ABA, OT, SLP)
Service/Therapy (Type) 1: _____
Where did the service take place? School _____ Home Provider_____ Office_____

Is the client currently receiving services from this provider? ___Yes ___No If No, please indicate when services were provided: Month/Year _____ to Month/Year_____

If yes, how many hours per week of services are provided _____

Provider address:_____
_____
Phone Number: _____ Fax Number_____
Email Address:_____

Do you authorize CIHS to contact this provider to obtain information, if we determine that it may be helpful in our provision of ABA services for the client? ___Yes ___No
What progress did you observe during the time the client received services from this provider?

_____
_____
_____
_____
If you are no longer receiving services from the above provider, please tell us why.
_____
_____
_____

Service/Therapy (Type) 2: _____
Where did the service take place? School _____ Home Provider_____ Office_____

Is the client currently receiving services from this provider? ___Yes ___No If No, please indicate when services were provided: Month/Year _____ to Month/Year_____

If yes, how many hours per week of services are provided _____

Provider address:_____
_____
Phone Number: _____ Fax Number_____
Email Address:_____
Do you authorize CIHS to contact this provider to obtain information, if we determine that it may be helpful in our provision of ABA services for the client? ___Yes ___No

What progress did you observe during the time the client received services from this provider?

_____
_____
_____
_____

If you are no longer receiving services from the above provider, please tell us why.

_____
_____
_____

Service/Therapy (Type) 3: _____
Where did the service take place? School _____ Home Provider_____ Office_____

Is the client currently receiving services from this provider? ___Yes ___No If No, please indicate when services were provided: Month/Year _____ to Month/Year_____

If yes, how many hours per week of services are provided _____

Provider address:_____
_____
Phone Number: _____ Fax Number_____
Email Address:_____
Do you authorize CIHS to contact this provider to obtain information, if we determine that it may be helpful in our provision of ABA services for the client? ___Yes ___No
What progress did you observe during the time the client received services from this provider?

_____
_____
_____
_____

If you are no longer receiving services from the above provider, please tell us why.

_____
_____
_____

Medical History

Physician: _____ Phone Number:_____
Is the client currently taking any medication? Yes _____ No_____

- **Medication 1 _____ Dosage: _____**

Administration Times: _____ Used for: _____

- **Medication 2 _____ Dosage: _____**

Administration Times: _____ Used for: _____

- **Medication 3 _____ Dosage: _____**

Administration Times: _____ Used for: _____

- **Medication 4_____ Dosage: _____**

Administration Times: _____ Used for: _____

- **Medication 5 _____ Dosage: _____**

Administration Times: _____ Used for: _____

Are the client vaccinations up to date? ___Yes ___No
Does the client currently have an infectious disease? Yes_____No _____

If yes, please explain what type/kind of disease, date of onset, medications being taken and if the client is currently contagious.

_____
_____
_____

Did any complications arise during pregnancy with the client? Yes_____ No_____
If yes, please explain:_____

_____
_____
_____

Are there concerns about the client's hearing? Yes _____ No_____
Has a hearing assessment been conducted? Yes _____No____

List any childhood illnesses that the client has experienced:

_____
_____
_____
_____

Does the client use any of the following:

- **Nicotine/Tobacco? Yes _____ No_____ How many per day?_____**
- **Alcohol? Yes _____ No_____ If yes: Beer_____ Liquor_____ Wine_____**

If Yes, how many drinks?_____ How Often?_____

- **Use of any recreational drugs? Yes_____ No_____**

If yes, What type of drugs do you use?_____
How Often Do You Use drugs? _____

Developmental History

At what age did the client reach these milestones? (Please answer "NO" if the client is not yet able to accomplish any of the following behaviors):
Sit up independently: _____ Crawl: _____ Walk: _____ Eat solids: _____
Sleep through the night: _____ At what age did you suspect the client was not developing normally? _____ Has the client exhibited any loss of skills in any area?
Yes _____ No____ If yes, please explain:_____
_____
_____
_____

Social Play and Skills

Describe how the client engages in play:
_____
_____
Does the client play independently? Yes _____No _____ If yes, for how long? _____
Are there any specific items and/or toys the client likes to play with?
_____
Does the client play with toys appropriately?Yes _____No_____ If no, please explain:
_____
_____
_____
Does the client attempt to involve others in play?Yes ____No_____ Sometimes_____

If not, please explain. If yes, please describe how the client involves others in play?
_____
_____
_____

Does the client engage in interactive play with others their age? Yes ____ No_____ If no, please explain. If yes, please describe how the client interacts with others?

_____
_____
_____

Does the client engage in pretend play? ___Yes ___No If yes, please explain.

_____
_____
_____

Communication Skills

How does the client communicate?
Pointing _____ Gestures _____Sounds ___Short phrases _____ Sentences_____

Describe the client's spontaneous vocalization/ language:

_____
_____
_____
_____

Does the client respond when his/ her name is called? Yes____ No____ If yes, please describe how he/she responds.

_____
_____
_____
_____

Describe how the client communicates what he/she wants:

_____
_____
_____
_____

Does the client follow simple directions?
Always _____ Most of the time _____ Sometimes _____ Never_____

Does the client make eye contact?
Always _____ Most of the time _____ Sometimes _____ Never_____
Does the client label items/ events/ actions?
Always _____ Most of the time _____ Sometimes _____ Never_____

Does the client engage in verbal exchanges with others?
Always _____ Most of the time _____ Sometimes _____ Never_____

Please indicate if the client can do the following:

Identify numbers: Yes_____ No_____
Matching items: Yes_____ No_____
Identify letters: Yes_____ No_____
Complete puzzle: Yes_____ No_____
No If yes, what kind?
Draw: Yes_____ No_____
Identify people: Yes_____ No_____
Motor Skills: Yes_____ No_____

Can the client imitate simple gestures (e.g., clapping, waving)? Yes____ No_____

Can the client imitate simple behaviors using objects (e.g., banging on drum)?
Yes ___ No____

Describe the client's general gross motor abilities (e.g., running, jumping):
_____
_____
_____
_____

Describe the client's general fine motor abilities (e.g., stacking blocks, cutting with scissors):_____
_____
_____
_____

.

Is the client toilet trained? Yes ____ No____

Please describe how the client feeds himself/herself (e.g., Fingers, use utensils)?

_____
_____
_____
_____

Does the client dress him/ herself independently? Yes ____No____

Does the client clean up after him/ herself independently?
Always ____ Most of the time ____ Sometimes ____ Never____

Top things you should know about the client:

Key Strengths: _____
Key Likes: _____
Favorite Rewards: _____
Key Anxieties: _____

Behaviors of Concern

Have you observed the client demonstrate any of these behaviors?

1. Self- stimulatory behaviors (e.g., vocal sounds, flapping hands, lining up objects):
Yes ____No____ If yes, please explain which behaviors the client engages in.

How frequently and how often?

_____
_____
_____

2. Self- injurious behaviors (e.g., banging head on hard objects, eye poking):
Yes ___No___ If yes, please explain which behaviors the client engages in.

How frequently and how often?

_____
_____
_____
_____

3. Unsafe behaviors to self (e.g., running away, climbing furniture):Yes ____No____
If yes, please explain which behaviors the client engages in, how frequently and how often?

_____
_____
_____
_____

4. Unsafe behaviors to others (e.g., hitting, throwing objects, biting): ___Yes ___No
If yes, please explain which behaviors the client engages in. How frequently and how often?

_____
_____
_____
_____

5. Ritualistic/ Obsessive behaviors (e.g., wearing same clothes every day, talks only about one topic): ___Yes ___No
If yes, please explain which behaviors the client engages in. How frequently and how often?

_____
_____
_____
_____

6. Other behaviors of concern:

_____
_____
_____
_____

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality of the client's health information, and are required by law to do so. This notice describes how we may use your health information within Changing Lanes Intervention Human services and how we may disclose it to others outside of Changing Lanes Intervention Human services. This notice also describes the rights you have concerning your own health information. CLIHS must follow the obligations described in this notice and give you a copy of it. *Please review this notice carefully* and let us know if you have questions.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We are allowed and may be required to use or disclose health information about you for certain purposes without your authorization. Certain uses and disclosures of your health information, however, require your authorization. The following are ways in which we may use or share your health information:

Treatment

We may use the client's health information to provide them with treatment services. We may also disclose your health information to others who need that information to treat the client, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, Insurance providers and other facilities which may be involved in your care. *For example, we will allow your physician to have access to your treatment record to assist in your treatment and for follow-up care.*

We also may use and disclose your health information to contact you, to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

Payment

We may use and disclose your health information to insurers and health plans to be paid for the services or supplies rendered to you. For example, your Health Plan or Health Insurance Provider may ask to see parts of your health information before disbursement for your treatment.

We may use and share the client's health information to run our organization, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services. Family Members and Others Involved in Your Care Unless you object, we may disclose your health information to a family member or close friend who is involved in your healthcare, or to someone who helps to pay for your care. We also may disclose your health information to disaster relief organizations to help locate a family member or friend in a disaster.

Business Associates

We may disclose your health information to our third-party service providers (“Business Associates”) that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our Business Associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

OTHER USES AND DISCLOSURES

Required by Law Federal, state, or local laws sometimes require us to disclose client health information. For instance, we are required to disclose client health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA. We also are required to give information to Workers’ Compensation Programs for work-related injuries.bPublic Health Activities We may report certain health information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the state government. We also may need to report adverse reactions to medications or medical products to the U.S. Food and Drug Administration (the “FDA”), or may notify clients of recalls of medications or products they are using.

Public Safety

We may disclose health information for public safety purposes in limited circumstances. We may disclose health information to law enforcement Officers in response to a search warrant or a grand jury subpoena. We also may disclose health information to assist law enforcement Officers in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct within Changing Lanes Intervention Human services. We also may disclose your health information to law enforcement Officers and others to prevent a serious threat of health or safety.

We may disclose health information to a government agency that oversees CLIHS or its personnel for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Judicial Proceedings

CLIHS may disclose health information if ordered to do so by a court order or if a subpoena or search warrant is served. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your health information.

Marketing/Sale of Information

We will never sell your information or share your information for marketing purposes unless you give us written authorization. If we contact you for any fundraising efforts, you can ask that we do not contact you again related to fundraising..

Information with Additional Protection

Certain types of health information have additional protection under state and federal law. For instance, health information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and evaluation and treatment for a serious mental illness is treated differently than other types of health information. For those types of information, CLIHS is required to get your written authorization before disclosing that information to others in many circumstances.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

If CLIHS wishes to use or disclose your health information for a purpose that is not discussed in this notice, CLIHS will seek your authorization. If you give your written authorization to CLIHS, you may take back that authorization any time, unless we have already relied on your authorization to use or disclose information. If you would ever like to revoke your authorization, please notify the Privacy Officer in writing. Restrictions on Disclosure of PHI to Health Plan CLIHS must abide by a request to restrict disclosure of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Your Health Information You have the right to look at the client's health information and to get a copy of that information. Please note that exceptions may apply as provided by law. (The law requires us to keep the original record.) This includes the client's health record, your billing record, and other records we use to make decisions about your care. To request for the client's health information, call or email to the Privacy Officer at the contact information below. If you request a copy of your information, we will charge you for our costs to copy the information and a search and retrieval fee. We will tell you in advance what this record request will cost. You can look at your record at no cost. Right to Request Amendment of Health Information You Believe is Erroneous or Incomplete If you examine the client's health information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your health information, submit a written request to the email address below. We may deny your request, but we will respond to your request with an explanation within 60 days.

Right to Get a List of Certain Disclosures of Your Health Information

You have the right to request a list of many of the disclosures we make of your health information. If you would like to receive such a list, submit a written request to the email address below. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost and you may choose to modify or withdraw your request at that time.

Right to Request Restrictions on How CLIHS Will Use or Disclose Your Health Information for Treatment, Payment, or Health Care Operations

You have the right to ask us NOT to make uses or disclosures of the client's health information to treat the client, to seek payment for care, or to operate the system. We are not required to agree to your request, but if we do agree, we will comply with that agreement. If you want to request a restriction, write to the Privacy Officer at the email address below and describe your request in detail.

You have the right to ask us to communicate with you in a way that you feel is more confidential. *For example,* You can ask us not to call your home/cell/work, but to communicate only by email or mail. To do this, please discuss this with your caregiver, or submit a written request to the Privacy Officer to update changes at the email address below. You can also ask to speak with your health care providers or staff in private outside the presence of other clients. Our clinical supervisors are easily accessible for any concerns you may have.

Right to be Notified Following a Breach of Unsecured PHI

You have the right and will be notified if the client's health information has been breached as soon as possible, but in any event, no later than sixty (60) days following our discovery of the breach.

Right to Choose a Representative

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure this person has the authority and can act for you before we take any action.

Rights, Responsibilities and Ethics

Clients have the right to actively participate in treatment, explanation of treatment, the right to refuse treatment, the right to confidentiality, the right to appeal, reasonable access to care and the right to have respect from our providers. Patients are also expected to provide accurate information, follow policies and procedures and follow financial obligations.

CHANGES TO THIS NOTICE

From time to time, we may change our practices concerning how we use or disclose client health information, or how we will implement client rights concerning their information. We reserve the right to change this notice and to make the provisions in our new Notice effective for all health information we maintain. If we change these practices, we will post a revised Notice of Privacy Practices. You can get a copy of our current Notice of Privacy Practices at any time by requesting one from the Privacy Officer at the contact information below.

Changing Lanes Intervention Human servicesAcknowledgement of Receipt of Notice of Information and Privacy Practices

Client Name: _____

I have been given a copy of Changing Lanes Intervention Human services, Notice of Information and Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Changing Lanes Intervention Human services has the right to change this Notice at any time.
I may obtain a current copy by contacting the Privacy Officer at (770)580-4116 or at the following email address: info@clihumanservices.com.

My signature below acknowledges that I have been provided with, and I have read, a copy of the Notice of Information and Privacy Practices and that I understand the contents and I have had an opportunity to ask any questions that I may have regarding this copy.

_____ _____
Signature of Client or Parent/Guardian Date

_____
Print Name Personal Representative's Title
(e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Informed Consent and Service Agreement

I, _____, as the client of Changing Lanes Intervention Human services ("Client") or, if applicable, *as the parent or guardian of the Client*, give my consent for Changing Lanes Intervention Human services to provide Assessment and Behavior Analytic Services to the following individual, _____("Client"), in accordance with the ethical guidelines proposed by the Behavior Analytic Certification Board (BACB).

I also understand that I may withdraw my consent and terminate treatment in writing at any time and for any reason. I understand that any information provided in this intake as well as any information obtained at any point during the interview process or course of treatment, is kept strictly confidential in accordance with HIPAA regulation guidelines and the law. I understand that state laws may require that confidentiality be broken under certain circumstances, specifically, if I am judged by the behavior analyst to be of danger to myself and/ or others, or if there is suspected child abuse.

I understand that Changing Lanes Intervention Human services is bound to strict ethical guidelines of practice and that any issues of concern that may arise throughout the treatment process that are out of the behavior analyst's area of experience may result in referrals to a more appropriate agency or individual.

_____ _____

Signature Date

Limits of Confidentiality

Contents of all therapy sessions are to be considered confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or client's legal guardian. Noted exceptions are as followed:

Duty to Warn and Protect

When a client discloses intentions or plans to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the healthcare professional is required to notify the legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he/she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Court Order

If our records, or subcontractor records or staff testimony are subpoenaed by court order, we are required to produce requested information or appear in court to answer questions regarding the client.

Parental Exposure to Controlled Substances

Mental health care professionals are required to report admitted parental exposure to controlled substances that are potentially harmful.

Minor/ Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: Types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, data collection during services and summaries.

I agree with the above limits of confidentiality and understanding the meanings and ramifications.

_____
Signature of Client or Parent/Guardian

_____
Print Name

_____
Date

Notifying Changing Lanes Intervention Human services About Changes Agreement

I understand that I must notify Changing Lanes Intervention Human Services of the following changes before my next visit: Any changes to my referring doctor, Any changes to my current insurance provider(s), Any therapy benefits being used outside of Changing Lanes Intervention Human Services. I also understand that failure to notify Changing Lanes Intervention Human services of the above may result in a claim denial from the insurance company and/or third-party payers and I am fully responsible for any outstanding balance on my account.

In the event that my insurance and/or third-party payer(s) deny a claim based on the above, I understand I will be billed by Changing Lanes Intervention Human Services and I agree to pay for the full amount of therapy time/ services and any outstanding balance on the client's account.

_____

Print Name of Client or Parent/Guardian

_____

Signature of Client or Parent/Guardian

_____

Date

Payment Policy Agreement

I, _____, agree to pay Changing Lanes Intervention Human Services for all services provided or missed/ canceled without 24 hours prior notice and agree to abide by the following guidelines:

Therapy sessions- out of pocket pay

You will receive an expense invoice on a biweekly or monthly basis for services provided to the client by Changing Lanes Intervention Human Services. This invoice will include client responsibility such as deductible, copays, co-insurance and other out of pocket expenses until your annual out of pocket maximum is met. Credit cards or checks will be accepted for all payments due on the date indicated on the invoice. In certain situations, we can work out a payment plan at the discretion of the Changing Lanes Intervention Human Services guidelines..

Understanding the Importance of Cancellations and Missed Appointments

At Changing Lanes Intervention Human Services, we try our best to accommodate our clients and families we service. We set up excellent administration systems that can make the services we provide run smoothly. One big challenge of running a smooth therapy program is when scheduled therapy sessions are canceled. When a therapist cancels within 24 hours of session (unless an emergency) or, multiple times even more than 24 hours before sessions, it is unacceptable and is dealt with by the corporate office under strict terms. When a client cancels the therapy session, it offsets our schedule and may result in the therapist discretion to stop services after 3 missed appointments/ cancellations without 24 hour notice. So, upon these guidelines, we may send you an invoice for missed or canceled sessions, which must be paid in full before you are able to schedule another appointment.

Canceled Therapy Sessions

If there is an *occasional issue* such as a doctor's appointment, emergency or family occasion and you need to cancel a therapy session, you must provide 24 hours' notice to the therapist and your primary contact at Changing Lanes Intervention Human Services office or you may be billed for the full session as this is not billable to insurance. If there is 24 hours' notice, we will try our best to accommodate you. These accommodations must be made through and approved by the office of Changing Lanes Intervention Human Services Lead staff department.

In the event of *an unexpected illness or emergency* in which 24 hours' notice cannot be provided, you are required to provide at least **2 hours' notice** prior to the start of a scheduled appointment in order to prevent being billed for the full session which is not covered by insurance.

If There is *No Notice of Late Arrival to Session* When a client arrives late to a scheduled appointment, he/she may be billed the rate of the full appointment even if it will not be covered by applicable insurance coverage. The therapist will wait **10 minutes** from the initial appointment time, if the client is not there by then, the therapist is permitted to leave and/or move on to the next client. The client will be considered absent/No Show and the session will not be rescheduled. You may be billed for the full session and this is not billable to insurance.

Repeated failures to attend scheduled sessions or frequently arriving late to scheduled sessions *may result in termination of services*.

I have read, understand and agree to the above guidlines of the payment policy

_____
Print Name

_____ _____
Signature Date

Card Payment Authorization Form Agreement

Please fill in your information so we can have a credit card on file even if you don't have a Copay. You authorize charges to your credit card.In the result of breaching the Cancellations and Missed Appointments Agreement, Payment Policy Agreement and Notifying About Change Agreement I understand I will be billed by Changing Lanes Intervention Human Services and I agree to pay for the full amount of therapy time/ services and any outstanding balance on the client's account. You will be charged the amount indicated by an invoice each billing period prior to charges. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided unless the date or amount changes as stated on invoice, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize Changing Lanes Intervention Human Services to
(Cardholder's Name) charge my Credit Card indicated above to Agreements.

Billing Information

Billing Address _____ Phone # _____
City, State, Zip _____ Email _____

Card Details: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____
Account/CC Number _____ Expiration Date ____ /____ CVV ____
Zip Code _____

In the result of Breaching the Cancellations and Missed Appointments Agreement, Payment Policy Agreement and Notifying About Change Agreement I understand I will be billed by Changing Lanes Intervention Human Services and I agree to pay for the full amount of therapy time/ services and any outstanding balance on the client's account with the above card information. I agree to Authorize all charges to the card above, granting permission to Changing Lanes Intervention Human Services. I understand that this authorization will remain in effect until I cancel it in writing providing a replacement form of payment. I agree to notify Changing Lanes Intervention Human Services in writing of any changes in my account information at least 14 days prior to the next billing date that will be issued in agreement of an invoice . If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these transactions; so long as the transactions correspond to the terms indicated in this authorization form.

Signature _____ Date _____
(Cardholder's Signature)

Parent/Guardian Guidelines

Your cooperation on the following is greatly appreciated to assist us in working successfully with the client

1) Parents/guardians and therapist should be respectful and courteous to each other. Open communication between parents/guardians and therapists is essential to the establishment of a successful program for the client. All communication must be done in a courteous and respectful manner. If there are any problems or concerns, please contact Changing Lanes Intervention Human Services Lead staff department. immediately (770) 580-4116.
2) The client should be dressed and fed prior to the therapist's arrival unless these skills are being addressed in the program.
3) A parent/guardian or responsible adult must be in the home when therapy is being provided.
4) Parent training is expected as active parent participation is required for best possible treatment.
5) The area being used for therapy must be a comfortable temperature and well lit.
6) The area where therapy is provided must be safe and secure for both the client and the staff. If the staff member feels that the environment does not adhere to safety and security regulations, he/she will immediately leave and inform the corporate office within one working day.
7) The materials and reinforcers used for therapy should not be used outside of therapy time.
8) The therapist is NOT allowed to take a client in their automobile.
9) Sickness: Please notify the therapist, as much in advance as possible, at least the night before the scheduled session if you know that the client will not be able to participate in the program the next day. Sickness includes, but not limited to the following:
Temperature above 100, mumps, pinworms, communicable disease, chicken pox, strep throat, foot/mouth disease, measles, lice, vomiting, diarrhea, rash, pink eye, monkeypox, Covid.
Parents/guardians are asked to use the same guidelines used in a school - if a client 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 client's doctor clears him/ her of being contagious or the remedy is completed. If a therapist arrives at the home and the client is sick, the therapist will not be able to work on the client. It will be counted as an unexcused cancelation and you may be billed for the session and this is not billable to insurance.

10) The parents/guardians cannot change therapy hours with therapists. You must contact the scheduling department for a schedule change request. Please keep in mind you may have services put on hold until a therapist can be assigned and your current therapist and/ or supervisor may not be your clinical staff once the requested time changes.
11) The therapist will call the family if they are going to be arriving more than 5 minutes late. If the therapist does not call, the parents/guardians should report it to the corporate office.
12) If a therapist cancels a session, the parents/guardians should report it to the Changing Lanes Intervention Human Services office. 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) In the case of snow or inclement weather: Please listen to the radio for announcements of school closing for the district in which you reside. If the district schools are closed it is an indication that driving in that area presents danger and the therapist should not report to work that day. 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.
14) In case of an accident or unusual incident, the therapist and the family should inform the corporate office within 1 working day (24hours).
15) Parents/guardians are encouraged to share any information about the client in a professional manner with the therapist, that may be helpful for the therapist to work successfully with the client.
16) The telephone numbers of all therapists should be available. Responses should be within 24-48 hours and parents/guardians must confirm with their therapist available times to reach them.

I Understand and agree to the Parent/Guardian guidelines:

_____ _____
Signature of Client or Parent/Guardian Date

Consent to Treatment Contract

First Name/Last Name:_____

You are about to take a very important step in your mental wellness plan, and you are seeing a mental health professional. As your mental health provider, we will be entering into a protected relationship. Treatment might involve a multidimensional family approach. Due to this consent is needed for all those attending sessions.

We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with a normal emotional development. This may include recommendations of therapy, or medications. This is all part of the service of a mental health professional. We will also work with your primary care physician to assure coordination of care.

(Initial)_____

You are our client and have confidentiality rights. Confidentiality does not apply under certain situation: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide or other dangerous behavior, we will inform you.

If I require or think it is in your best interest to communicate with an outside source, I will request a release of information. To assure good therapeutic care, frequent appointments are required. Unless arranged otherwise, clients that have not been seen in 3 months will be considered inactive. A new evaluation will be required for any inactive client to be seen.

(Initial)_____

I,_____(client), do hereby seek and consent to take part in the treatment provided by Changing Lanes Intervention Human Service LLC private provider Ashley Martin, LPC. If I am attending group services I also understand and consent that confidentiality still applies and that Changing Lanes Intervention Human Services, LLC is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this mental health professional.

(Initial)_____

I am aware that I may stop treatment with this mental health professional at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

(Initial)_____

I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. In the event that my information is intercepted, CLI Human Services is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Phone :_____
Email :_____

(Initial)_____

Client Name (please Sign):_____

Date:_____

HIPAA Notice/Privacy Practices Contract

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please review it carefully*.

First Name:_____ Date of Birth:_____
Last Name:_____

We at Changing Lanes Intervention Human Services understand the importance of privacy and are committed to maintaining the confidentiality of your information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice please contact our office.

Our office can be notified by email at ***info@clihumanservices.com.***
CEO Ashley Martin

Client Name (please Sign):_____

Date:_____

Authorization for Release of Information

Patient First, Last Name:_____
Date of Birth:_____

We respect your personal information and want you to know your rights as a client of Changing Lanes Intervention Human Services. Please read the information below.

PATIENT RIGHTS

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

PATIENT AUTHORIZATION

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

I hereby authorize Changing Lanes Intervention Human Services to **RELEASE** my protected health information (PHI) To:Name:_____
Address:_____City:_____
State:_____ Zip:_____ Phone:_____
Fax:_____ Email:_____

I hereby authorize Changing Lanes Intervention Human Services to **OBTAIN** my protected health information (PHI) From: Name:_____
Address:_____City:_____
State:_____ Zip:_____ Phone:_____
Fax:_____ Email:_____

Disclosure may include the following verbal or written information: (check all that apply)

- ☐ Face sheet History & physical
- ☐ Laboratory/diagnostic testing results
- ☐ School information
- ☐ Discharge summary
- ☐ Medication records
- ☐ Behavioral health/psychological consult
- ☐ Psychosocial assessment/Family history
- ☐ ER record report
- ☐ Psychiatric evaluation
- ☐ Substance abuse treatment records
- ☐ HIV/AIDS lab results & treatment history
- ☐ Progress & Case Notes
- ☐ Summary of treatment records & contact dated
- ☐ Psychological evaluation/testing results
- ☐ Tense/unable to relax
- ☐ Afraid to leave home
- ☐ Excessive worry
- ☐ Inflated self esteem
- ☐ Panic attacks
- ☐ Feel guilty or worthless
- ☐ Thoughts of death or suicide
- ☐ Other :_____
- ☐ Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.
- ☐ *All Listed Above* **Signature**:_____ **Date**:_____

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by Changing Lanes Intervention Human Services without my written consent. I understand that this authorization will remain in effect for:

- ☐ The period necessary to complete all transactions on accounts related to services provided to me.
- ☐ One (1) year
- ☐ Other:_____

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If the client is a minor child, I verify that I am the legal guardian/custodian of this child.

Name Print:_____ Date:_____

Signature:_____