WEDGWOOD
CHRISTIAN SERVICES
TRANSFORMING LIVES ONE CHILD AT A TIME

Autism Center for Child Development
Intake Packet

Today's Date: _____|_____|_____
month | day | year

IDENTIFYING INFORMATION

Child Information
Name: _____ DOB: _____/_____/_____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____-_____-_____ Sex: _____ Height: _____ Feet _____ Inches Weight: _____ lbs.

Parent Information
Mother's Name: _____ Home Phone: _____
Cell phone: _____ Work Phone: _____ Other: _____
Address: _____ City: _____ State: _____ Zip: _____
Father's Name: _____ Home Phone: _____
Cell phone: _____ Work Phone: _____ Other: _____
Address: _____ City: _____ State: _____ Zip: _____

Name of Person Completing this Form: _____ Relationship to applicant: _____
Phone: _____ email: _____

Person Responsible for Payment, if different from above: _____
Who referred you to us? _____

Please describe the problems your child is now having: _____
_____
_____
_____

FAMILY INFORMATION

Mother's Name: _____
Father's Name: _____
Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single
If Divorced: Who has physical custody? _____ Full or Joint? _____
Mother: ☐ Remarried ☐ Cohabitating ☐ Single
Step-Father's Name: _____
Father: ☐ Remarried ☐ Cohabitating ☐ Single
Step-Mother's Name: _____

Siblings: Please list all siblings

Name	Relationship	Age	Living at Home?

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Please list any other people who currently live in the home:

Name _____ Relationship _____ Age _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

LANGUAGE INFORMATION

Client primary language: _____

Parent primary language:_____

Primary language spoken at home:_____

MEDICAL/DIAGNOSTIC INFORMATION

Please list your child's current and past diagnoses:

Current Primary Diagnosis: _____

Current Secondary Diagnosis: _____

Other Current Diagnoses: _____

Past Diagnoses: _____

Who diagnosed your child? _____

Contact information of doctor/clinic where child was evaluated: _____

Does your child have any of the following? (Check all that apply)

	Yes	No	Don't Know	Describe
Seizures				
Visual Impairment				
Hearing Problems				
Special Diet				
Food Allergies				
Other Impairment (describe)				

Please list any serious illnesses, injuries, hospitalizations, or special conditions:

_____

_____

_____

Are your child's immunizations up to date? _____ Yes _____ No

Medications:

Current Medications	Dosage	Schedule	Reason Prescribed

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Name of Child's Physician(s): _____
Physician's Address: _____ Phone: _____ Fax: _____
Other information: _____
_____
_____

EDUCATIONAL INFORMATION

Does your child currently receive any special education services? _____ Yes _____ No
Services child receives (include school-based or private services): _____
_____
_____

Current teachers/daycare providers: _____ Grade: _____ School: _____
Please list any concerns your child's teacher has about him/her: _____
_____
_____

OTHER SERVICES

Does your child receive therapy or other services beyond school time? If so, please list the service provider:

Occupational Therapy:	_____ Yes	_____ No	Provider: _____
Physical Therapy:	_____ Yes	_____ No	Provider: _____
Speech Therapy:	_____ Yes	_____ No	Provider: _____
Behavior Therapy:	_____ Yes	_____ No	Provider: _____
Other:	_____ Yes	_____ No	Provider: _____

BEHAVIOR STATUS

Please check all that apply:

Communication:

☐No discernible speech sounds (may grunt, growl, screech, etc., but does not babble or make speech sounds)
☐1 to 2 discernible speech sounds (list: _____)
☐3 to 5 discernible speech sounds (list: _____)
☐Babble consisting of 5+ speech sounds (list at least 6 sounds: _____)
☐Can say at least 10 words (list common words or approximations used: _____
_____)
☐Echolalia (repetitive)
☐Uses words or short phrases to communicate wants and needs or label
☐Primary mode of communication is sign language. Approximate number of signs _____
☐Primary mode of communication is PECS. Approximate number of PECS _____
☐Primary mode of communication is technological device (such as Dynavox, i-Pad app, etc.) Please specify device: _____

Motor or Vocal Self-Stimulatory Behaviors (examples: making noises/repetitive phrases, hand flapping, spinning, rocking, mouthing, jumping):

☐Motor self-stimulatory behaviors occur in most all settings, including during interactions with others
☐Vocal self-stimulatory behaviors occur in most all settings, including during interactions with others
☐Motor self-stimulatory behaviors occur primarily when the child is not engaged by another person

☐Vocal self-stimulatory behaviors occur primarily when the child is not engaged by another person
☐Does not engage in motor or vocal self-stimulatory behaviors

Aggression to Self:

☐_____ times per day ____ times per week
☐_____ occurs only at school ____ occurs only at home ____ occurs in all environments
☐Self-injurious behaviors cause injury such as bleeding or bruising
☐Self-injurious behavior causes redness that does not bruise
☐Self-injurious behavior occurs at low frequency that does not cause injury
☐Does not engage in self-injurious behaviors

Aggression to Others:

☐____ times per day ____ times per week
☐____ occurs only at school ____ occurs only at home ____ occurs in all environments
☐____ occurs towards adults only ____ occurs towards children only ____ occurs to children and/or adults
☐Physically aggressive behaviors against others cause bleeding or bruising
☐Physically aggressive behaviors against others cause redness that does not bruise
☐Physically aggressive behaviors against others occur at a low frequency that does not cause injury
☐Does not engage in aggression to others

Exhibits any of the Following:

☐Aggression to environment/property, such as throwing/turning over furniture, destroying materials, etc.
If yes, ____ times per day, _____ per week
☐Responds to sudden environmental changes (example: loud noises, presence/absence of people).
If yes, list triggers: _____
☐Pica (ingestion of inedible substances). If yes, ____ times per day, _____ per week
List examples of items ingested: _____
☐Unauthorized departure. If yes, ____ times per day, _____ per week
In what situations is this most likely? _____
☐Verbal aggression. If yes, ____ times per day, _____ per week
☐Spitting. If yes, ____ times per day, _____ per week
☐Inappropriate sexual behaviors (☐ touching self ☐ touching others). If yes, ____ times per day, ____ per week
☐Non-compliance. If yes, ____ times per day, _____ per week
☐Theft. If yes, ____ times per day, _____ per week
☐Other: _____
_____
_____

ADAPTIVE BEHAVIOR

Please tell us about the child's level of independence with the following skills:

Self-Help Skill	Independent	Verbal or Visual Prompts	Physical Assistance
Toileting			
Dressing			
Eating			
Bathing			
Grooming			
Self-Administration of Medication			

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BILLING INFORMATION

PLEASE ATTACH FRONT/BACK COPY OF INSURANCE CARD

Name of Third Party Coverage: _____

Policy Holder's Name: _____ SSN: _____-_____-_____ DOB: ___/___ /___

Address: _____ Phone #: _____

Policy #: _____ Place of Employment: _____

Group #: _____ Effective Date: ___/___ /___

Type of Plan:

□ Commercial (Group Plan) □ HMO □ PPO □ Medicaid □ Medicaid HMO

□ Medicare □ Medicare Supplement □ Other: _____

CONSENT TO BILL INSURANCE PLAN(S)

My signature below indicates that:

☐I give permission for Wedgwood Christian Services to bill my insurance company for covered services; and to exchange information necessary to secure payment for these services. Such necessary information may include my child's diagnosis, service dates, types of services and other information related to Wedgwood's services necessary to process claims.

☐I understand that if an insurance payment is made directly to me for Wedgwood's services, I am responsible for paying Wedgwood from that money. Failure to do so can constitute insurance fraud.

☐I will notify Wedgwood of any changes to my child's health insurance coverage, as well as any denial information.

☐I understand that I am responsible for any balance that my insurance company does not authorize for payment, including by an insurance company with whom Wedgwood is out-of-network

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

_____ _____

Signature of Wedgwood Designee Date

_____

Child(ren)'s Name(s)

Attach photocopy of front of insurance card here	*Attach photocopy of back of insurance card here*

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EMERGENCY CLIENT INFORMATION

Client Name: _____ D.O.B.:_____

Address: _____

Parent/Guardian Name(s):_____

Phone #: _____ Alt. Phone #:_____

IN CASE OF AN EMERGENCY PLEASE CONTACT

Primary contact: _____ Relationship:_____

Phone #: _____ Alt. Phone #:_____

Secondary contact: _____ Relationship:_____

Phone #: _____ Alt. Phone #:_____

Hospital Preference:_____

Additional information that may be helpful in the event of an emergency (Ex: Allergies or other medical concerns):

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date

_____ _____

Wedgwood Representative Signature Date

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CONSENT FOR OTHERS TO PICK UP CHILD/RECEIVE INFORMATION ABOUT CHILD'S DAY

Please note: Visitors may be asked to show identification

Client's Name: _____ DOB: _____

The following individuals may visit my child at the ACCD in my absence and may be given information related to his/her treatment that day:

First & Last Name; Relation to Child	May take child from the ACCD	May be told about client's day
_____	☐Yes ☐No	☐Yes ☐No
_____	☐Yes ☐No	☐Yes ☐No
_____	☐Yes ☐No	☐Yes ☐No
_____	☐Yes ☐No	☐Yes ☐No
_____	☐Yes ☐No	☐Yes ☐No
_____	☐Yes ☐No	☐Yes ☐No
_____	☐Yes ☐No	☐Yes ☐No
_____	☐Yes ☐No	☐Yes ☐No

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (Please print) _____

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DOCUMENTATION OF DIAGNOSTIC EVALUATION AND INDIVIDUALIZED EDUCATION PLAN (IEP)

Please attach documentation of your child's diagnosis as it was given by a physician, psychiatrist, psychologist, or other qualified professional. Please provide the entire diagnostic report, including the assessment measures used and results for each assessment or test. This is required before your intake packet can be processed. Also include copy of most recent IEP, if applicable. When completed, the entire intake packet with documentation should be sent to:

Postal Mail:
Autism Center for Child Development
Wedgwood Christian Services
3300 36th St SE
Grand Rapids, MI 49512

Fax:
Attention: Autism Center for Child Development
(616)808-3916

E-mail: (please scan intake paperwork and diagnostic report and attach documents to e-mail)
Subject Line: Intake Packet for Autism Center for Child Development
Jvandyke2@wedgwood.org (Jessica Van Dyke)

Drop off in person at our physical address:
1260 Ekhart St. SE
Grand Rapids, MI 49503

NOTICE OF INTERPRETATION SERVICES

☐I speak limited English. I need competent language assistance in _____ to have full and effective access to your services.

☐I am fluent in English. I do not need language assistance.

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OUTPATIENT FINANCIAL AGREEMENT

Client: _____ Parent/Guardian: _____ Date: _____ Time: _____

You are responsible for the cost-sharing requirements (deductible, coinsurance, and/or copays) determined by your contract with your insurance company. You are also responsible for the cost of any services not covered by your insurance policy. The estimated client portion for your session is payable at the time of each appointment. Any exception to this policy must be arranged in advance with a member of the billing staff. Payment by cash, check, Visa or MasterCard is expected at the time of service. A $25.00 fee will be assessed on all returned checks.

Please remember that your insurance policy is a contract between you and the insurance company. We will submit insurance claims on your behalf; however, the final responsibility for all charges remains with the client, including co-pays and deductibles. A separated or divorced parent who brings a child for treatment will be responsible for paying our office directly and seeking reimbursement, if necessary, from the other parent. If you have Medicare or Medicaid, please let us know. We will file all Medicare and/or Medicaid claims for you.

We will do our best to approximate your charges before your visit; however, fees vary according to the type of services you receive.

Be sure to call your insurance company for information regarding your anticipated charges and whether the charges will be covered by insurance. There are additional charges for psychological testing and some telephone work (emergency and client/doctor, client/therapist calls), court appearances, or any time spent working on your behalf, and will be billed accordingly.

Prompt and consistent payment of your bill is greatly appreciated. In the event that your unpaid balance reaches $200 or more and/or you have not made the payments for 4 or more sessions, services will be temporarily suspended. Services will resume once at least 50% of the balance is paid with continuing efforts to pay the remaining balance and any new charges.

We want to work closely in partnership with you and your therapist to ensure that your time with Wedgwood is as productive as possible. If your personal circumstances change in a way that affects your ability to pay, including a change in insurance coverage, please contact our billing department immediately. Let us work with you before your bill becomes an additional cause of concern to you.

I have read and understand the above policies of Wedgwood Christian Services. I authorize Wedgwood Christian Services to release to my insurance company any information necessary to secure reimbursement for charges by me or my minor child.

I hereby authorize the payment of medical benefits to Wedgwood Christian Services and understand I am financially responsible for charges not paid by my insurance company.

_____ _____ _____ _____

Client/Person Assuming Responsibility for Charges Date Wedgwood Representative Date

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CONSENT FOR TREATMENT

Client: _____ Parent/Guardian: _____ Date: _____ Time: _____

1. I have come to Wedgwood for evaluation, treatment, and/or referral. I understand that these services may be provided by social workers, psychologists, psychiatrists, behavior analysts, behavioral technicians, and other mental health professionals. I understand that Wedgwood provides Person-Centered Planning in that I participate in my/my child's goals and treatment.

2. I am aware that some people may not benefit from mental health services. I acknowledge that no guarantees have been made to me as to the results of services and treatment provided by Wedgwood.

3. I am aware that, depending on the requirements of my insurer or referral source, information about the services received may be accessible in a computerized information system at times by providers of other services I/my child am/is authorized to receive.

4. I understand that I may ask questions about the risks and benefits of any treatment procedures, and/or medications prescribed to me/my child.

5. I am aware that Wedgwood is a faith-based organization, and that I have the right to seek alternative services.

6. I understand that my consent for treatment is freely given and I may discontinue treatment at any time, but there may be risks involved and I will discuss it with my/my child's therapist or doctor.

7. I consent to use and disclosure of the protected health information about myself or my child or ward for treatment, payment and health care operations as described in the Notice of Privacy Practices. This means that information about me or my child/ward's health will be used by Wedgwood or disclosed to other people or organizations wherever needed to provide treatment to me or my child/ward or arrange for treatment by another health care provider, arrange payment for services to me or my child/ward, operate the business of Wedgwood, and to enable other health care organizations that provide treatment to me or my child/ward or pay for services for me or my child/ward, to review the quality and appropriateness of care I or my child/ward receives and conduct other health care operations.

   I understand that information disclosed pursuant to this consent may be re-disclosed by the recipient of information.
   I understand that there is no time limit on this consent. I also understand that I may revoke this consent at any time.

NOTICE OF RECIPIENT RIGHTS

1. I understand that I have certain rights as a recipient of services of Wedgwood Christian Services, including the right to a second opinion if I disagree with treatment recommendations that result from my/ my child's clinical evaluation. I have received a) a recipient rights booklet, and b) a local appeals form.

2. Information may be released to proper authorities if it is necessary to keep others or myself/my child from being harmed. This includes abuse, neglect, exploitation, and endangerment.

3. I understand that I may contact the Client Rights Advisor at Wedgwood, or the Recipient Rights officer of my county's Community Mental Health office.

Signature: _____ Date _____
Client/Legal Guardian or Custodial Parent of minor client

Signature: _____ Date _____
Wedgwood Representative

ATTENDANCE POLICY AND PARTICIPATION EXPECTATIONS

Treatment Approach and Regular Attendance

The Autism Center for Child Development (ACCD) employs a research-supported approach to early intensive behavioral intervention. Upon referral, we typically conduct an intake evaluation and 1-2 additional assessment sessions. If we agree to continue with enrollment into the ACCD, regular attendance is very important. If you are unable, for any reason, to attend regularly we may choose to discontinue treatment. If treatment is ended prematurely, for any reason, we will work with you to find treatment alternatives as needed.

Expectations

If you agree to enroll your child in the ACCD, you will be asked to help implement the strategies used in the ACCD at home. This is to help assure that the skills will transfer to the home and community environments. Parents/guardians are expected to participate in one home visit and at least one session observation per quarter (approximately once every 3 months). Parents are also expected to attend treatment planning meetings with the supervisor regularly to discuss their child's individual program.

Parents are expected to foster their child's independence at all times; for example, having the child walk into the building, carry his/her own bag, and open the door. Parents are also expected to continue using the teaching strategies in the home and community environments, in order to facilitate generalization of skills.

Clients are expected to attend all scheduled sessions. Please call the clinic ahead of time if your child will not be attending (see Cancellation Policy on the next page). If a client misses sessions without notice, he or she may be terminated from services and referred to other agencies. If sessions are cancelled frequently, the client may be terminated from services and referred to other agencies, at the discretion of the ACCD.

Parents will be asked to supply the following items to daily sessions:

- Change of clothes
    - Closed Toe shoes
- Diapers (if needed)
- Wipes
- Water bottle/cup to have beverages drank throughout the day with child's initials clearly printed
- Healthy lunch, including a drink (if child's session occurs over the lunch hour)
    - Food must be cut up and ready to eat; please cut food length wise to avoid choking hazards
    - Silverware, plates, and cups that are needed for lunch
- Other necessary care items your child may need

CANCELLATION POLICY

Policy

- Advanced notice must be given for planned absences. If you or your child will miss therapy or appointments due to vacation, doctor's appointments, special events, or any other non-emergency reason, it is important you let us know ahead of time. This includes parent/guardian appointments such as session observations, home trainings, treatment planning meetings, etc. **Except in cases of emergency, at least 48 hours' notice is required for all cancelled appointments.**
- In the case of illness, 1 hour notice is expected (24 hours' notice is preferred) for all cancellations.
- If you cancel or alter sessions less than 48 hours prior to the scheduled time 3 or more times in any 60-day period for any reason, your child's services will be placed on probation for 30 days (see below).
- If you or your child do not attend a session and no notice is provided by ½ hour past the scheduled start time ("No call/no show"), you will receive a warning. If it occurs again, your child's services will be placed on probation for 30 days.
- If your child does not arrive on time for the scheduled therapy session, that day's session will be canceled and the therapist will be sent home at 30 minutes past the scheduled start time. We cannot accommodate floating arrival times. If this occurs more than 3 times in any 30-day period, your child's services will be placed on probation for 30 days.
- If you or your child is more than 15 minutes late (for arrival or pick up) for a scheduled appointment or therapy session three or more times in any 30-day period, your child's services will be placed on probation for 30 days.
- You and your child must obtain 80% attendance over 30 days to therapy sessions and appointments with your BCBA. If you and your child's attendance drop below 80% your child's services will be placed on probation for 30 days. We may make exceptions for preapproved family vacations and serious illness, with a doctor's note, at discretion of the ACCD.

Probation Status

- Probation status lasts 30 days. If the following criteria are met during probation, probationary status will be removed and services will continue.
    - You and your child arrive on time (that is, before the session start time) for 90% of sessions and appointments
    - Your child is picked up on time (that is, parent arrives before the scheduled end of session) for 90% of sessions
    - You and your child have zero "No call/no shows" for sessions and appointments
    - You and your child have zero late cancellations (that is, altering the session less than 48 hours prior to the scheduled start time)
    - You and your child with attend 80% or more of therapy sessions, and appointments
- If these criteria are not met during the probationary period, services may be discontinued so another child waiting for services may receive treatment.
- If your child's services are placed on probation three or more times in a 12-month period, services may be discontinued so another child waiting for services may receive treatment.

Procedures

- Provide at least 48 hours' notice for planned absences from treatment. Planned absences may be scheduled up to one year ahead of time – please let us know as soon as possible when you know your child will not be in attendance for a scheduled session.
- Call as soon as you decide not to bring your child to session due to sudden illness or urgent need (1 hour notice is expected). Please call (616) 965-3492 and leave a message on the office voicemail if you call before or after ACCD center hours..
- ALL schedule changes (cancellations, vacations, illness, delays, appointments, etc.) must be communicated directly by the parent to the ACCD Department Assistant, by phone. To make a change to your child's schedule, please call (616) 965-3492. You may leave a voicemail.
- Changes cannot be made by telling a therapist at pick up or drop off.
- If you need to make an adjustment to a previous cancellation (for example, you were planning to go out of town but your trip was rescheduled), please contact the ACCD Department Assistant right away. We will make every effort to reinstate the session, but please understand that this may not always be possible due to other children's and therapists' schedules.

Rationale

Therapists are scheduled 1:1 to work with your child. Because of how services are billed, if your child does not attend a session, the therapist must be sent home and does not get paid. Therapists depend on consistent work to pay their bills, schedule child care, and carry health insurance. Additionally, ensuring a consistent work schedule reduces turnover of therapists, thereby increasing consistency for your child.

Many limited resources go into providing 1:1 therapy. You might be surprised to learn that it costs more than $150 per hour to provide these services to your child. Please keep this in mind when scheduling appointments, vacations, and other events that may interfere with your child's therapy.

Acknowledgement

I have read and understand the above cancellation policy.

_____
Parent/Guardian Name

_____ _____
Parent/Guardian Signature Date

_____
Child's Name

GROUPING PRACTICES

As we are committed to keeping you informed of practices used in your child's therapy, we would like to inform you that we are now occasionally providing ABA therapy sessions where some of our clients are "grouped" meaning 2 clients are receiving ABA therapy from 1 staff for a portion of the day. We group clients for whom it is clinically appropriate for the following reasons: to increase opportunities for social skills, practice group instruction, practice flexibility, increase independent play skills, or to tolerate diverted attention from adults. Grouping allows us to address some client needs that are difficult to address in 1:1 therapy. We will choose to group clients either if we deem it to be a necessary treatment for a client or if we do not have staff available to provide 1:1 staffing for all clients and deem that we have clients in the center that day for whom grouped therapy would be clinically beneficial. Please note that, unless deemed clinically necessary, clients who are grouped are only grouped during part or some of their ABA sessions and receive 1:1 therapy the rest of the time to work on goals that are best achieved through individual rather than group instruction. Please note that if it is not deemed clinically appropriate or safe to group a client, they will receive only 1:1 therapy. If you have questions, please contact your child's clinician (BCBA).

Participation Consent

Research

Data from the ACCD may be presented as clinical research in professional lectures, conferences, events, or journals. In the case that the data are presented, your child's personal information (e.g., name) will be de-identified from his/her data. You also may be contacted to participate in research studies if these opportunities become available. Your consent to participate in research will be documented and reviewed in a separate consent form and will not affect your enrollment or services provided to your child.

Confidentiality

There will be up to 10 children attending therapy in the same classroom at the same time. All the participants will be identified with each other by first name only. Supervisory and direct-care staff will keep the information about the other clients confidential. Because of the nature of working in a classroom setting, we cannot guarantee that information exchanged during treatment sessions will be protected from peers or parents during observation. It is important to remember that the purpose of early intervention is not to discuss or address sensitive issues, but rather skill acquisition for skills not yet exhibited and skill deceleration for any problematic behaviors. Do not hesitate to ask any questions about the therapy. We appreciate your cooperation very much and hope that your child will participate in the program.

Contact Information

If you have any questions or concerns, please feel free to contact Dr. Lake at (616) 965-3470.

****

I have read the above information on the ACCD. I understand that any information about me or my child gathered as part of the program will not be shared with anyone outside the program in a form that would identify me or my child. I have had all my questions about the program answered to my satisfaction, and I hereby give my consent for my participation and that of my child. In signing this form, I understand that this participation is strictly voluntary and that I am free to withdraw my permission at any time.

Child's Name _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____

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POLICY FOR MANAGING INAPPROPRIATE BEHAVIOR

Inappropriate behavior such as screaming, throwing a tantrum, refusing to comply with instructions, running away, engaging in self-stimulatory behavior, and hitting often draw attention to the child with autism spectrum disorder. They also interfere significantly with learning. Challenging behavior must be addressed in order to prepare the child to maximize his/her opportunities for learning and socialization in a mainstream placement. The Autism Center for Child Development focuses on positive reinforcement. The following techniques, in accordance with the principles of Applied Behavior Analysis (ABA), are employed to increase desirable behavior and reduce unwanted behavior.

- Social stories – to explain visually what is required of the student
- Breaking the task down to ensure success
- Rearranging the work area to promote attention to task and reduce distractions
- Mixing harder tasks with easier tasks
- Redirecting back to task using various prompts
- Using momentum drills to re-focus student
- Reinforcing alternative behavior while ignoring inappropriate behavior
- Working through the task when the child cries or tantrums, giving no attention to problem behavior.

Note: If the child continues to display dangerous behavior:
Immobilization – holding the child so staff/students cannot be hurt and using momentum drills to get child to respond, then returning to original task.

Parents are requested to read and sign this form to acknowledge that they understand the behavior management practices carried out in the Autism Center for Child Development. If your child requires Immobilization, you will be notified and an individualized behavior plan will be developed in consultation with you.

I have read the above and agree to the implementation of the appropriate behavior management strategies to be implemented with my child as outlined.

Child's Name _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____

CONSENT FOR ADMINISTRATION OF MEDICATION

I, parent/legal guardian of the below named child, authorize trained staff members of Wedgwood Christian Services to monitor and administer medication(s) per my written directions. It is my responsibility to notify the staff, in writing, of any changes in medications, dosages, administration times, or procedures.

Medications:
_____
_____
_____
_____

I parent/legal guardian of the below named child, authorize the staff of Wedgwood Christian Services to act in my behalf in case of accident, injury or illness when immediate medical or surgical care is needed.

Medical Responsibility: I further agree to assume financial responsibility in the event of accident, injury or illness of my child while in the care of Wedgwood Christian Services. If I cannot be reached, I hereby give permission to staff members of Wedgwood Christian Services to sign hospital operative permits for my child for such operations or dental procedures as are considered critically necessary by medical judgment, including administration of anesthesia.

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

_____ _____
Signature of Wedgwood Designee Date

_____
Child's Name

MEDICAL EMERGENCY TREATMENT AND TRANSPORTATION RELEASE

Wedgwood Christian Services has my permission to arrange for medical care and/or transport my child in case of an emergency. I hereby agree to indemnify and hold harmless Wedgwood Christian Services and its agents, employees, or contractors, whether paid or volunteer, against any claims which may arise from any injury that occurs during transportation.

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

E-MAIL CONSENT TO COMMUNICATE WITH HEALTH CARE PROVIDERS

I request to communicate with my child's health care provider (s) using electronic mail. I realize that the following risks and benefits apply.

RISKS:
The confidentiality of e-mail communication cannot be assured.
□ E-mail communication may be viewed by third parties.
□ E-mail is sent across an open computer network and is generally unencrypted. It is thus accessible to prying eyes similar to a postcard.
□ E-mail sent using an employer's e-mail system could legally be read by the employer.
□ The biggest threat to the confidentiality of e-mail is not hackers intercepting messages, but messages that are mis-addresses, mistakenly forwarded to others, or are read using shared e-mail accounts or on computer screens when one forgets to log-off.

BENEFITS:
□ Use of e-mail may eliminate "telephone tag" between patient and health care provider.
□ Non-urgent messages and questions may be communicated with less interruption than by phone.
□ E-mail allows a written record of communication which can be a useful reference.

GUIDELINES FOR E-MAIL COMMUNICATION:
Appropriate uses of e-mail for medical communication include:
□ Address and telephone numbers of referring facilities;
□ Test results with interpretation and recommendation;
□ Medication instructions and refill information;
□ Before-admission and after-discharge instructions;
□ Patient education;
□ Questions and answers about issues discussed during a previous visit;
□ Questions and answers about new symptoms by an established patient;
□ Verification of future appointment dates/times;
□ Other messages of a similar nature to the topics above.

E-mail SHOULD NOT be used to communicate:
□ Emergencies and other time-sensitive issues
□ Requests for medical advice before the patient-physician relationship has been established
□ Sensitive information, defined as any information that the patient would not want anyone other than the health care provider to have.

Additional Recommendations:
□ Put patient name in the subject line
□ Keep copies of e-mail you receive from your health care provider
□ Your health care provider will be saving and/or printing e-mail messages to be filed in your child's medical record. Your health care provider may share your messages with his/her office staff or consultants if necessary. This consent form applies to all health care providers who are providing care to your child at this clinic. E-mail correspondence may be terminated by either the patient/guardian or health care provider at any time.

I, _____ (name of parent/guardian) understand the risks, benefits, and appropriate uses of e-mail communication with my child's health care providers. I recognize that the confidentiality of medical information discussed in e-mail communication cannot be assured and I accept that risk. I understand that it is my responsibility to identify for my health care providers any medical information that I expressly do not want communicated via e-mail. I agree to follow the guidelines listed above. I agree to follow the guidelines listed above regarding the appropriate and inappropriate uses of e-mail communication with my child's health care providers.

I have reviewed the information above and wish to proceed.

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

_____
Child's Name

Autism Center for Child Development
Intake Packet

PHOTO AND VIDEO RELEASE

Client: _____ Parent/Guardian: _____ Date: _____ Time: _____

I hereby give permission for photographs and/or video images to be taken of _____ for the following purposes (check yes or no for each item):

☐Yes ☐ No Myself/client's legal guardian(s) to view
☐Yes ☐ No For use to teach other clients (peers) to identify my child and call him/her by first name
☐Yes ☐ No Internal training with Wedgwood employees not directly involved in treatment
☐Yes ☐ No External trainings (examples may include parent or school staff trainings)
☐Yes ☐ No Website/brochure

_____ I do not consent to any photographs or videos taken of my child to be used in any manner that does not pertain directly to my child's treatment.

I understand the pictures and/or video images may be taken during assessment or therapy for treatment purposes; however, without parental consent these images will only be seen by individuals directly involved in my child's treatment. If permission is given for images to be used for other purposes, I understand that it is Wedgwood's policy that persons in photos not be identified by name. Photos and/or video may be used with permission until parental consent is revoked. Parents may revoke consent at any time.

Child's Name _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (Please print) _____

CONSENT FOR SHARING PHOTOS/VIDEOS BY EMAIL

_____ I hereby give permission for photographs and/or video images to be shared with specified persons via e-mail. I understand e-mail transmission is not secure and give my permission for Wedgwood to send photos or videos of my child via e-mail to the recipients designated below.

Photographs and/or video images may be sent to the following email address(es):
_____
_____
_____

Parent/Guardian Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

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

Wedgwood has adopted the following policies and procedures for protection of the privacy of the people we serve.

Our Obligation to You

We at Wedgwood respect your privacy. This is part of our code of ethics. We are required by law to maintain the privacy of "protected health information" about you, to notify you of our legal duties and your legal rights, and to follow the privacy policies described in this notice. "Protected health information" means any information that we create or receive that identifies you and relates to your health or payment for services to you.

Use and Disclosure of Information about You

Use and Disclosure for Treatment, Payment and Health Care Operations.

We will use your protected health information and disclose it to others as necessary to provide treatment to you. Here are some examples:

- Various members of our staff may see your clinical record in the course of our care for you. This may include therapists, case workers, direct care workers, support services workers (e.g., activities therapists, nurses, employment specialists, etc.), and their respective supervisors.
- It may be necessary to send blood or tissue samples to a laboratory for analysis to help medical staff evaluate your medical condition.
- We may provide information to your health plan or another treatment provider in order to arrange for a referral or clinical consultation.
- We may contact you to remind you of appointments.
- We may contact you to tell you about treatment services that we offer that might be of benefit to you.

We will use or disclose your protected health information as needed to arrange for payment for service to you. For example, information about your diagnosis and the service we render is included in the bills that we submit to the person or entity that pays for your care (which may be, in some cases, a health insurance plan). Your payer plan may require health information in order to confirm that the service rendered is covered by your benefit program and medically necessary. A health care provider that delivers service to you, such as a clinical laboratory, may also need information about you in order to arrange for payment for its services.

It may also be necessary to use or disclose protected health information for our health care operations or those of another organization that has a relationship with you. For example, our quality assurance staff reviews records to be sure that we deliver appropriate treatment of high quality. Your payer may wish to review your records to be sure that we meet national standards for quality of care.

Our Policy

It is our policy to obtain a general written permission to use and disclose your protected health information for treatment, payment or health care operations purposes. You will be asked to sign a Consent form to permit all such uses and disclosures of your information.

Emergencies. If there is an emergency, we will disclose your protected health information as needed to enable people to care for you.

Disclosure to Your Family and Friends. You as an adult, have the right to control disclosure of information about you to any other person, including family members or friends. If you ask us to keep your information confidential, we will respect your wishes. But if you don't object, we will share information with family members or friends involved in your care as needed to enable them to help you.

Disclosure to Health Oversight Agencies. We are legally obligated to disclose protected health information to certain government agencies, including the federal Department of Health and Human Services.

Disclosures to Child Protection Agencies. We will disclose protected health information as needed to comply with state law requiring reports of suspected incidents of child abuse or neglect.

Other Disclosures Without Written Permission. There are other circumstances in which we may be required by law to disclose protected health information without your permission. They include disclosures made:

- Pursuant to court order;
- To public health authorities;
- To law enforcement officials in some circumstances;
- To correctional institutions regarding inmates;
- To federal officials for lawful military or intelligence activities;
- To coroners, medical examiners and funeral directors;
- To researchers involved in approved research projects; and
- As otherwise required by law.

For those who participate in alcohol or drug abuse programs, we will follow the provisions of 42 CFR Part 2 governing disclosure of protected health information. Except for the circumstances described above, we will not disclose protected health information to a third party without your written permission of the individual or a court order. If a request for disclosure of your client record is received, you will be contacted and asked whether you wish to authorize disclosure. If you refuse to authorize disclosure, or it is not possible for us to contact you person, we will not disclose your information without a court order.

Disclosures With Your Permission. No other disclosure of protected health information will be made unless you give written Authorization for the specific disclosure.

Your Legal Rights

Right to Request Confidential Communications. You may request that communications to you, such as appointment reminders, bills, or explanations of health benefits be made in a confidential manner. We will accommodate any such request, as long as you provide a means for us to process payment transactions.

Right to Request Restrictions on Use and Disclosure of Your Information. You have the right to request restrictions on our use of your protected health information for particular purposes, or our disclosure of that information to certain third parties. We are not obligated to agree to a requested restriction, but we will consider your request.

Right to Revoke a Consent or Authorization. You may revoke a written Consent or Authorization for us to use or disclose your protected health information. The revocation will not affect any previous use or disclosure of your information.

Right to Review and Copy Record. You have the right to see records used to make decisions about you. We will allow you to review your record unless a clinical professional determines that would create a substantial risk of physical harm to you or someone else. If another person provided information to our clinical staff in confidence, that information may be removed from the record before it is shared with you. We will also delete any protected health information about other people.

At your request, we will make a copy of your record for you. We will charge a reasonable fee for this service.

Right to "Amend" Record. If you believe your records contains an error, you may ask us to amend it. If there is a mistake, a note will be entered in the record to correct the error. If not, you will be told and allowed the opportunity to add a short statement to the record explaining why you believe the record is inaccurate. This information will be included as part of the total record and shared with others if it might affect decisions they make about you.

Right to an Accounting. You have the right to an accounting of some disclosures of your protected health information to third parties. This does not include disclosures that you authorize, or disclosures that occur in the context of treatment, payment or health care operations. We will provide an accounting of other disclosures made in the preceding six years. If requested by law enforcement authorities that are conducting a criminal investigation, we will suspend accounting of disclosures made to them.

Right to a Paper Copy of this Notice. You have the right to a paper copy of any Notice of Privacy Practices posted on our web site (www.wedgwood.org).

How to Exercise Your Rights

Questions about our policies and procedures, requests to exercise individual rights, and complaints should be directed to our Contact Person.

Our Contact Person is the Client Rights Advisor. The Contact Person can be reached at (616) 942-2110.

Personal Representatives. A "personal representative" of a client may act on their behalf in exercising their privacy rights. This includes the parent or legal guardian of a minor. In some cases, adolescents who are "mature minors" may make their own decisions about receiving treatment and disclosure of protected health information about them. If an adult is incapable of acting on his or her own behalf, the personal representative would ordinarily be his or her spouse or another member of the immediate family. An individual can also grant another person the right to act as his or her personal representative in an advance directive or living will.

Disclosure of protected health information to personal representatives may be limited in cases of domestic or child abuse.

Complaints

If you have any complaints or concerns about our privacy policies or practices, please submit a Complaint to our Contact Person. If you wish, the Contact Person will give you a form that you can use to submit a Complaint if you wish.

You can also submit a complaint to the United States Department of Health and Human Services. Send your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
OCR Hotlines-Voice: 1-800-368-1019

We will never retaliate against you for filing a complaint.

Effective Date: This policy was approved by the Board of Directors of Wedgwood on April 8, 2003.

It is effective April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT

I have received a copy of the following:

☐ **Notice of Privacy Practices of Wedgwood Christian Services**

☐ **Community Mental Health Client Rights Handbook**

_____

Client Name (print clearly)

_____ _____

Parent/Guardian Signature Date

_____ _____

Wedgwood Representative Signature Date