Enrollment Application

Dear Parents/Legal Guardians,

Thank you for your interest in our center-based autism services at Partners in Excellence. Our mission is to positively impact the life of each child through our unparalleled commitment and desire to see our clients reach their greatest potential. Treatment services are aimed at developing and improving your child's communications skills, increasing social interactions with others, expressing and coping with emotions and developing self-regulation strategies.

To ensure that your child receives the most beneficial treatment, the initial assessment of your child is critical. The information you provide within this packet will be utilized to provide the treatment team with a history and background of your child's life and will help establish treatment goals and provide us with necessary information to secure authorization for treatment. It is important to complete all the sections as thoroughly as you can. The results of this evaluation will guide the direction of treatment and ensures that the treatment goals are appropriate for your child's optimal growth and development. This is important baseline information for you so that you can have an accurate understanding of your child's current abilities as well as a basis for comparison to measure progress in treatment over time.

This document must be completed and returned within **30 calendar days** of your initial phone call with intake staff in order to be considered for services. Your child's file will become active once this packet and all additional required documents have been received and reviewed.

If you have any further questions or concerns, please contact intake staff:

For Burnsville, Minnetonka, North St. Paul: 952-818-2876
For La Crosse, Winona: 608-785-4100

Evaluations/ Assessments

The following reports are required as a part of your enrollment application:

✓	**Evaluations / Assessments** ** All documents must have been completed within the past 12 months*
	Comprehensive Psychological Evaluation – this is an evaluation by a *Ph.D. level licensed psychologist*. This evaluation ***must include an IQ test*** to assess your child's cognitive (mental) capabilities **AND** must be completed within the last 12 months. (please include all previous evaluations as well)
	Autism-specific Diagnostic Assessment – this evaluation can be completed within either the Psychological Evaluation or the Speech/Language Assessment. This includes the use of any of a variety of diagnostic tools (CARS, ADOS, etc), which are designed to evaluate specifically for the symptoms of autism spectrum disorders. (please include all previous evaluations as well)
	Medical Evaluation - this is an examination by a *licensed physician*. (only the most recent evaluation is needed)
	Audiology Evaluation – this is an evaluation of your child's hearing by a *licensed physician* or *specific audiologist*. (only the most recent evaluation is needed)
	Comprehensive Speech/Language Evaluation – this is an evaluation by a *licensed Speech/Language Pathologist*. (only the most recent evaluation is needed)
	Occupational Therapy Evaluation - this is an evaluation completed by a *licensed occupational therapist*. (only the most recent evaluation is needed)
	Physical Therapy Evaluation – this is an evaluation completed by a *licensed physical therapist* (only the most recent evaluation is needed)
	Feeding Therapy Evaluation – this is an evaluation completed by a *licensed occupational therapist or speech and language pathologist* (only the most recent evaluation is needed)
	Copy of Education Plan – most recent Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) (only the most recent IEP/IFSP is needed)
	Copy of Insurance Card(s) – copy of FRONT and BACK of **ALL** insurance cards.

Enrollment Application

* Use only black ink when filling out this form

Date of completion: ____/____/____Your name/relationship to child: _____
Preferred location: _____ 2nd preferred location: _____

Child's personal information:					
First name	MI	Last name	Gender ☐ Male ☐ Female	Date of Birth	Age ___years ___months
Home address	City	State	Zip Code	County	
Mailing address (if different)	City	State	Zip Code	County	

Parent/Guardian 1: Is parent 1 the legal guardian? ☐ Yes ☐ No				
First name	Last name	Relationship to child	Home phone	Cell phone
Is parent 1's address the same as child's? ☐Yes ☐ No - if no, fill in below				
Home address	City	State	Zip Code	
Email for parent/guardian 1:	Parent/guardian occupation			

Parent/Guardian 2: Is parent 2 the legal guardian? ☐ Yes ☐ No				
First name	Last name	Relationship to child	Home phone	Cell phone
Is parent 2's address the same as child's? ☐Yes ☐ No - if no, fill in below				
Home address	City	State	Zip Code	
Email for parent/guardian 2:	Parent/guardian occupation			

Current living situation:	
Child lives: ☐ home with family ☐ foster care ☐ group home ☐ other (describe) _____	
Parents are:	☐ birth parents ☐ Adoptive parents ☐ other _____
Parents are:	☐ married ☐ separated ☐ divorced ☐ other-explain _____

Child's race and ethnicity:		
Check all that apply	☐ Asian ☐ African-born ☐ Black or African-American ☐ White ☐ American Indian or Native Alaskan ☐ Pacific Islander or Native Hawaiian ☐ Other (specify) _____	Hispanic or Latino? ☐ yes ☐ no

Language:		
What is primary language spoken at home?	☐ English ☐ Other (specify) _____	
Language Interpreter used? ☐ yes ☐ no	If So, What Language?	Sign language interpreter used? ☐ yes ☐ no

Cultural considerations:
-Are there any cultural considerations that need to be taken into account or that we should be aware of?

Check the box in each area that best describes you as a parent:				
Confidence	◯ I/we understand the diagnosis and feels competent about meeting my/our child's needs.	◯ I/we understand the diagnosis, but am/are uncertain about how to meet my/our child's needs.	◯ I/we have difficulty understanding the diagnosis and meeting my/our child's needs.	◯ I/we do/does not understand the diagnosis and do/does not know how to meet my/our child's needs.
Stress	◯ I/we experience low to moderate stress and manage it well.	◯ I/we experience times of moderate to high stress, but it is manageable.	◯ I/we have high level of stress, but usually have the capacity to cope with it.	◯ I/we have a high level of stress on a daily basis and struggle to cope with and manage the situation.
Perception of Quality of Life	◯ I/we indicate low to moderate impact of my/our child's disability on quality of life, but manage it well.	◯ I/we indicate times of moderate to high impact of my/our child's disability on quality of life, but it is manageable.	◯ I/we indicate high impact of my/our child's disability on quality of life, but usually have the capacity to cope with it.	◯ I/we indicate high impact of my/our child's disability on quality of life and struggle to cope with and manage the situation.

Any additional comments/concerns:

Parent/Caregiver training preferences:
At Partners In Excellence, we provide parent/caregiver training as an opportunity to help generalize the skills learned during therapy and to help address challenges that you may be experiencing as a parent/caregiver. Please indicate your preferences for family training (e.g. individual, group, home, center).

Significant events:
Describe any child or family events which may have impacted the child's development.

History of developmental conditions or mental health concerns in other family members:	
Family History of:	
Depression	☐yes ☐no If yes, whom _____
Anxiety	☐yes ☐no If yes, whom _____
Substance Abuse	☐yes ☐no If yes, whom _____
Autism	☐yes ☐no If yes, whom _____
Bi-polar Disorder	☐yes ☐no If yes, whom _____
Schizophrenia	☐yes ☐no If yes, whom _____
Learning Disabilities	☐yes ☐no If yes, whom _____
Developmental Delays	☐yes ☐no If yes, whom _____
Other	☐yes ☐no If yes, whom _____

Family strengths:
Describe your family's strengths:

Family members:
List out sibling names and their age and briefly describe your child's level of interaction or relationship.

Tell us about your child:

Initial Concerns:

Date/ Age symptoms were first noticed:	Describe Symptoms:
Who noticed the symptoms:	

Current concerns:

Social Skills:

Does your child show an interest in peers? ☐yes ☐no
Does your child engage in parallel play? ☐yes ☐no
Does your child engage in cooperative play? ☐yes ☐no
Does your child engage in age appropriate toy play? ☐yes ☐no
What does your child do for fun? _____
Does your child try to share his/her enjoyment with others? ☐yes ☐no
Does your child try to comfort others when they are hurt or sad? ☐yes ☐no
Does your child use a range of facial expressions? ☐yes ☐no

Communication Skills:

How does your child communicate his/her wants and needs? _____
Is your child verbal? ☐yes ☐no
If yes: How many words does your child typically use at once? _____
Does your child ask for items verbally? ☐yes ☐no
Does your child spontaneously label items? ☐yes ☐no
Does your child ask questions? ☐yes ☐no
Does your child answer questions? ☐yes ☐no
Can your child engage in conversations? ☐yes ☐no
Does your child use gestures? ☐yes ☐no
Can your child follow instructions? ☐yes ☐no
If yes: How many steps can he/she follow at once? _____
Does your child appear to understand what you are saying? ☐yes ☐no

Restrictive and Repetitive Behaviors:

Does your child become fixated on objects/activities? ☐yes ☐no
Does your child struggle with changes in routines? ☐yes ☐no
Does your child engage in repetitive toy play? ☐yes ☐no
Does your child display ritualistic behaviors? ☐yes ☐no
If yes: list out examples _____
Does your child engage in repetitive behaviors? ☐yes ☐no
If yes: list out examples _____
What does your child do when upset? _____
What causes your child to get upset? _____
How frequently does your child get upset? _____
Does your child have safety awareness? ☐yes ☐no
Please list out any other concerns: _____

Behavioral characteristics of your child:

Check those that apply:

- ☐ Generally happy/flexible
- ☐ Can share easily
- ☐ Repetitive behavior
- ☐ Self-abusive behavior
- ☐ Cooperative
- ☐ Short attention span, fidgety
- ☐ Impulsive/distractible
- ☐ Will try new/novel activities
- ☐ Seeks out touch
- ☐ Inflexible/resistant to change
- ☐ Destructive/aggressive
- ☐ Shy
- ☐ Plays well with others
- ☐ Poor eye contact
- ☐ Can Shift attention to your agenda
- ☐ Easily frustrated
- ☐ Withdrawn
- ☐ Avoids Touch
- ☐ Other: _____

Communication:

Check all that apply:

- ☐ Does not talk
- ☐ Uses only single words
- ☐ Hard to understand child's words
- ☐ Repeats sounds/words (echolalia)
- ☐ Unusual pitch to voice (high or low)
- ☐ Asks questions of others
- ☐ Was late to start talking
- ☐ Talks seldom
- ☐ Cannot make correct speech sounds (for age)
- ☐ Tries hard to communicate
- ☐ Talks too loud or too quiet
- ☐ Uses lots of gestures
- ☐ Can communicate "yes" How? _____
- ☐ Can communicate "no" How? _____
- ☐ Initiates conversation
- ☐ Asks for people
- ☐ Asks to do activities
- ☐ Talks about past or future
- ☐ Asks questions
- ☐ Responds to questions
- ☐ Talks about present

Receptive:

- ☐ Responds to name
- ☐ Can follow simple direction
- ☐ Can answer simple "wh" questions
- ☐ Can point to/pick up what you ask
- ☐ Can understand what you are saying
- ☐ Other: _____

Child's current form of communication:

- ☐ Gesturing (pointing, looking, ect)
- ☐ Sounds (non-word; I.e. grunting)
- ☐ Pictures (PEC's)
- ☐ Single words
- ☐ 4 or more word sentences
- ☐ Crying/tantrums
- ☐ Augmentative device (I-pad, Dynavox)
- ☐ Sign Language
- ☐ 2 to 4 word sentences

Check the box in each domain that best describes your child:				
Social Interaction	◯ Primarily initiates and responds to social interaction in a reciprocal manner appropriate to child's age. Generally does not interfere with functioning.	◯ Some initiation and response to social interaction in a reciprocal manner appropriate to child's age depending on activity.	◯ Requires moderate levels of support to initiate and respond to others in a social manner.	◯ Needs constant 1:1 support to notice and socially initiate and respond to others.
Social Communication	◯ Primarily demonstrates integrated use of verbal and non-verbal communication appropriate to child's age. Generally does not interfere with functioning.	◯ Some abnormalities in eye contact, body language and use of gestures for purposes communication.	◯ Moderate abnormalities in eye contact, body language and use of gestures for purposes communication.	◯ Total lack of facial expressions, body language and gestures for purpose of communication.
Restrictive, Repetitive Behaviors/ Interests	◯ Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input generally do not interfere with daily functioning.	◯ Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input cause mild interference with daily functioning. Can be verbally re-directed.	◯ Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input cause moderate interference with daily functioning. May need visual or physical re-direction.	◯ Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input cause significant interference with daily functioning are extremely difficult to re-direct. Requires physical re-direction.
Self-Care Skills	◯ Able to perform most age-appropriate self-help skills.	◯ Requires some assistance or verbal/visual cues, but performs some self-help skills independently.	◯ Requires moderate verbal, visual and hands-on assistance for most self-help skills.	◯ Requires constant hands-on assistance for all self-help and daily cares.
Challenging Behaviors	◯ Age appropriate behavioral challenges in familiar and unfamiliar environments.	◯ Mild behavioral challenges in one or more familiar and unfamiliar environments.	◯ Moderate behavioral challenges across most familiar and unfamiliar environments.	◯ Severe behavioral challenges across all familiar and unfamiliar environments.

Check the box in each domain that best describes your child:				
Expressive Communication	◯ Able to spontaneously verbally express ideas and needs at a level appropriate to the child's age.	◯ Some spontaneous verbal expression of simple familiar or rote phrases to communicate ideas or express needs.	◯ Limited spontaneous expression of single words, signs, gestures, and/or Picture Exchange Communication System (PECS) or other augmentative device to request items or basic needs.	◯ Child has no spontaneous functional communication strategies.
Receptive Communication	◯ Able to respond appropriately to familiar and unfamiliar verbal requests, at a level expected for age.	◯ Able to respond appropriately to simple familiar/rote verbal requests, but has difficulty responding to unfamiliar requests.	◯ Limited response to simple familiar requests even when paired with visual cues or gestures and is unable to respond even when paired with visual cues and gestures.	◯ Does not respond when spoken to or when words are paired with visual cues and/or gestures.
Cognitive Functioning	◯ Cognitive skills appear to be at or above age appropriate level. No interference with age appropriate activities and interpersonal and daily life functioning.	◯ Mild cognitive challenges present minimal interference with age appropriate activities and interpersonal and daily life functioning.	◯ Moderate cognitive challenges interfere with age appropriate activities and interpersonal and daily life functioning.	◯ Severe cognitive challenges interfere with all aspects of daily life including lack of age-appropriate activities and interpersonal and daily life functioning.
Safety	◯ Able to occupy self alone or with siblings safely for age appropriate periods of time.	◯ Able to occupy self safely depending on activity, but requires moderate level of supervision for child's age.	◯ Able to occupy self safely for brief periods of times, but requires high level of supervision for child's age.	◯ Requires constant supervision to ensure safety.
Support Needed	◯ Needs no assistance in participating in age appropriate activities.	◯ Able to participate in age appropriate activities with minimal adult support and cues.	◯ Requires moderate level of adult support and cues needed to participate in age appropriate activities.	◯ Requires constant adults support and cues to participate in all age appropriate activities.

Pregnancy and delivery:

Describe if the pregnancy was typical or atypical:

Was the pregnancy full term? ☐ yes ☐ no Birth weight ____ pounds _____ ounces
If no, please describe the length of the pregnancy:

Describe if labor and delivery was typical or atypical:

Was your child hospitalized after birth and/or admitted into NICU? ☐ yes ☐ no
If yes, for what and for how long:

Developmental milestones:

If your child has hit these milestones, please list the <u>age</u> at which the child exhibited the following skills; if they have yet to achieve these milestones, please put N/A:

Babbling _____
Combing Words _____
Rolled Over _____
Crawling _____
Walking _____
Use Utensils_____
Dry throughout the night _____
Brush teeth independently _____
Fasteners on clothing _____
Bathing self _____
Washing hands _____

First Word _____
Complete sentences _____
Sitting unsupported _____
Standing _____
Eating Table foods_____
Toilet trained _____
Sleeps throughout the night _____
Dress self _____
Tying Shoes _____
Brushing hair _____

Please list any sensory concerns for your child:

Has your child ever gained skills and lost them?
☐ yes ☐ no if yes, please explain:

Child strengths:

Diagnostic information:		
What is your child's primary diagnosis?		
Date first diagnosed?	Licensed Mental Health Professional / Physician who gave diagnosis	
Agency Name	Phone number:	Fax number:

List History of Therapies Received:

Speech Therapy: Frequency: _____Date Started:_____ Date Discharged: _____ ☐ Has never received services			
Name	**Credentials**	**Phone number**	
Agency/Clinic Name		**Fax number**	
Agency Street Address	**City**	**State**	**Zip Code**

Occupational Therapy: Frequency: _____Date Started:_____ Date Discharged: _____ ☐ Has never received services			
Name	**Credentials**	**Phone number**	
Agency/Clinic Name		**Fax number**	
Agency Street Address	**City**	**State**	**Zip Code**

Physical Therapy: Frequency: _____Date Started:_____ Date Discharged: _____ ☐ Has never received services			
Name	**Credentials**	**Phone number**	
Agency/Clinic Name		**Fax number**	
Agency Street Address	**City**	**State**	**Zip Code**

ABA Therapy: Frequency: _____Date Started:_____ Date Discharged: _____ ☐ Has never received services			
Name	**Credentials**	**Phone number**	
Agency/Clinic Name		**Fax number**	
Agency Street Address	**City**	**State**	**Zip Code**

Feeding Therapy: Frequency: _____Date Started:_____ Date Discharged: _____ ☐ Has never received services			
Name	**Credentials**	**Phone number**	
Agency/Clinic Name		**Fax number**	
Agency Street Address	**City**	**State**	**Zip Code**

Other: Frequency: _____Date Started:_____ Date Discharged: _____ ☐ Has never received services				
Name		**Credentials**	**Phone number**	
Agency/Clinic Name			**Fax number**	
Agency Street Address		**City**	**State**	**Zip Code**
Date started:	**Frequency:**	**Date of last evaluation:** include copy of evaluation	**Current** ☐ **yes** ☐ **no**	**Last 12 months** ☐ **yes** ☐ **no**

Medical History

Primary Care Provider:			
Name	**Title**		
Clinic Name	**Phone number**	**Fax number**	
Agency Street Address	**City**	**State**	**Zip Code**
Date last seen:	**Anticipated next visit:**		

Medical history:	
Hospitalizations	☐ yes ☐ no If yes, please describe and provide a date:
Surgery	☐ yes ☐ no If yes, please describe and provide a date:
Seizures	☐ yes ☐ no If yes, please describe when the seizures began and when the most recent one occurred:
Head Injuries/Loss of Consciousness	☐ yes ☐ no If yes, please describe and provide a date:
High Fevers	☐ yes ☐ no If yes, please describe and provide a date:
Other	

Prior Medical Evaluations:

Evaluation Performed	Date	By Whom	Reason/Result
Well child check/annual physical			
Social Emotional screening			
Developmental screening			
Hearing			
ENT/Allergies			
Neurology			
Genetic Testing			
Other:			

Are immunizations current? ☐ yes ☐ no If no, describe reason

Current medications and supplements (include additional sheets as necessary):

Does child take medications ☐ yes ☐ no - If yes, list below

Medication/ Supplements	Dosage	Frequency	Start Date	Reason for Use	Prescribing Physician

Allergies (include additional sheets as necessary):

Does the child have allergies? ☐ Yes ☐ No ☐ Don't know - If yes, explain type of allergy and reaction, including any Medication.

Allergy	Reaction

County case management services:				
Service	Yes?	Contact Name	Agency/County	Phone Number
Social Worker/Case Manager	☐			
Consumer Support Grant	☐			
Family Support Grant	☐			
DD Waiver	☐			
CADI Waiver	☐			
Other:	☐			

School services:
Does your child attend preschool? ☐ yes ☐ no - If yes, what is the name of the preschool?
Does your child attend school? ☐ yes ☐ no - If yes, what is the name of the school and district?
If your child attends school, what is his/her educational placement? ☐ regular education ☐ Special education
Does your child have an Individual Education Plan (IEP) ☐ yes ☐ no
Does your child have an Individualized Family Service Plan (IFSP)? ☐ yes ☐ no
If yes to either of the last two questions, when was the IEP or IFSP last updated? (mm/dd/yyyy)
Case Manager/IEP Manager's name and contact information:

Authorization for Treatment

Client's Name: _____

✓ **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR MEDICAL CARE:**
I authorize release of pertinent medical information to other treating healthcare providers, for purposes of my child's treatments at Partners In Excellence, and for business operations.
Initial: Yes _____ No _____

✓ **CLIENT'S RIGHT TO PRIVACY:**
I acknowledge that I have been given a copy of the Partners In Excellence Privacy Notice (HIPAA).
Initial: Yes _____ No _____

✓ **CLIENT'S RIGHTS AND RESPONSIBILITES:**
I acknowledge that I have been given a copy of the Partners In Excellence Client's Rights and Responsibilities.
Initial: Yes _____ No _____

✓ **AUTHORIZATION FOR COMMUNICATION VIA EMAIL:**
I authorize Partners in Excellence and its authorized personnel to use email as needed to communicate with me and internally for purposes of my child's treatments at Partners In Excellence, and for business operations.
Initial: Yes _____ No _____

✓ **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES:**
I authorize release of pertinent medical information to third party payers / insurance companies to determine payments related to treatment received.
Initial: Yes _____ No _____ ****If NO, we are unable to coordinate with your medical insurance. You will be billed directly.***

✓ **ASSIGNMENT OF BENEFITS:**
I authorize payment of benefits be made directly to Partners In Excellence for services provided to my child, the above named patient, by Partners In Excellence. I understand and agree that I am financially responsible to Partners In Excellence for charges not covered by insurance. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.
Initial: Yes _____ No _____ ****If NO, we are unable to coordinate with your medical insurance and you will be billed directly.***

The above information is warranted to be true. I hereby authorize Partners In Excellence to investigate any information obtained from me pertaining to my financial responsibility. By signing this form, I consent to and authorize Partners In Excellence to evaluate and provide treatment to my child, the above named patient.

Parent/Legal Guardian's printed name	Signature	Date

Picture/Video Release

Client Name:_____ Date of Birth:_____

Partners in Excellence uses photographs and/or videos of children receiving services in our center based program for the purposes of instructional analysis, training, reporting, and selected marketing pieces for program awareness.

I have indicated below that photographs/digital images, video clips, and/or quoted remarks may be used as follows: (Check all that you authorize)

Yes	No	
☐	☐	Staff/Client Photo Board
☐	☐	Pictures used internally for individual programming (ex. PECS books, Visual Schedules, Social Stories)
☐	☐	Video used to document programming
☐	☐	Video used for ongoing internal staff training purposes
☐	☐	Scrapbooks
☐	☐	Printed publications or materials (such as magazines, newspapers, brochures or flyers)
☐	☐	Electronic publications or presentations (TV or other broadcast media)
☐	☐	Websites (Partners website, Facebook)
☐	☐	I agree that my child's name and identity may be revealed in descriptive text or commentary in connections with the image(s).
☐	☐	I agree that the media may contact my family to speak with my child regarding his/her involvement with Partners In Excellence.
☐	☐	I authorize the use of these materials (as indicated above) indefinitely without compensation to me. All negatives, positives, prints, digital reproductions and video or audio recordings shall be the property of Partners In Excellence.

I give permission to Partners In Excellence and its authorized personnel to use email as needed to communicate with me regarding the treatment of my child.

Yes	No	
☐	☐	Email to parent: email address: _____
☐	☐	Email internally to staff

Printed Name: _____

Signature of Parent/Caregiver: _____ **Date:** _____

Emergency Plan (Page 1 of 3)

Child's personal information:					
First name	MI	Last name	Gender ☐ Male ☐ Female	Date of Birth	Age ___years ___months

Home address	City	State	Zip Code	County

Parent/Guardian 1:			
First name	Last name	Home phone	Cell phone

Is parent 1's address the same as child's? ☐ Yes ☐ No - if no, fill in below

Home address	City	State	Zip Code

Email Address

Parent/Guardian 2:			
First name	Last name	Home phone	Cell phone

Is parent 2's address the same as child's? ☐ Yes ☐ No - if no, fill in below

Home address	City	State	Zip Code

Email Address

Emergency contacts other than parents/guardians:		
Contact #1	Relationship	Phone numbers:
Contact #2	Relationship	Phone numbers:

The following people are authorized to pick up:		
Name	**Relation to Child**	**Phone Number**

The following people are restricted from contact with your child:	
Name	**Relation to Child**

Emergency Plan (Page 2 of 3)

Child's Physician:			
Name of physician	Name of Clinic		Phone number
Address	City	State	Zip Code

Dentist:			
Name of Dentist	Name of Clinic		Phone number
Address	City	State	Zip Code
Transport to which Hospital	City	Registered? ☐ yes ☐ no	Phone number

Current Medications (include additional sheets as necessary):

Does child take medications ☐ yes ☐ no - If yes, list below

Medication	Dosage	Frequency	Reason for Use	Administered by Partners Staff?
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no

Allergies (include additional sheets as necessary):

Does the child have allergies? ☐ Yes ☐ No ☐ Don't know - If yes, explain type of allergy and reaction, including any Medication.

Allergy	Reaction

Emergency action plan for seizures & allergies:

Child has a seizure history: ☐ yes ☐ no

Emergency Plan: 911 will be called if:

- Seizure lasts longer than _____ minutes (if the seizure lasts longer than 5 minutes, 911 will be called unless a note is provided from the doctor stating otherwise)
- Your child is having difficulty breathing
- Vomitus is aspirated
- A significant injury occurs during the seizure
- Status epilepticus occurs (continuous seizure)

Describe your child's typical seizure. What do you want Partners in Excellence staff to do (other than routine First Aid) if your child has seizure while at the center?

Call Parent when:

Call Physician when:

Emergency Plan (Page 3 of 3)

Additional Questions:
I give permission to Partners in Excellence to take whatever emergency(e.g. first aid, disaster evacuation, ect.) measures are judged necessary for the care and protection of my child while at Partners In Excellence.
☐ yes ☐ no

I give permission for my child to be transported to the appropriate medical facility by the local emergency unit for treatment.
☐ yes ☐ no

I give permission for a copy of this form to be sent with emergency transport personnel. ☐ yes ☐ no

I understand that in some medical situations, the staff will need to contact local emergency resources before the parent/guardian, child's physician, and or other adult acting on the parent/guardian's behalf. ☐ yes ☐ no

Parent/Guardian Signature_____ **Date**_____

****PLEASE NOTE A RELEASE NEEDS TO BE FILLED OUT FOR THE INDIVIDUALS NOTED FOR THE EMERGENCY CONTACTS AND THOSE WHO ARE ABLE TO PICK UP YOUR CHILD.****

Financial Agreement (Page 1 of 3)

This financial agreement sets Partners In Excellence's expectations regarding payment. Partners In Excellence (Partners) believes that financial arrangements should be discussed and understood prior to the onset of services and before any problems or concerns develop.

Prior to receiving services, Partners In Excellence will work with you to ensure that the funding source you are planning to use will pay for services. It is the parents' responsibility to monitor the funding source they are utilizing and to immediately notify Partners In Excellence of any changes to insurance or other coverage's.

When discussing payment for services with insurance companies; it is important that the insurance company clearly understands the type of services Partners In Excellence provides. Partners In Excellence provides Intensive Behavioral Therapy in a center-based program.

It is essential that Partners In Excellence is involved in the prior authorization process. To do this, it is necessary for you to provide our Intake and Billing staff with the required information that enables us to bill your insurance company. In some circumstances even participating insurance plans require you to pay a balance not covered. It is your responsibility to know what limitations, exclusions, deductibles or co-pays your plan has. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract and our financial relationship is with you, not your insurance company. It is also important to remember that an authorization is not a guarantee of coverage. If the policy does not cover the service, and an authorization is obtained it may not be paid and result in a private liability to the family. Additionally, Partners In Excellence will contact the insurance to verify coverage as a courtesy to the family. This does not remove the responsibility from the family to know and understand their insurance coverage. If they do not pay or follow the coverage quotes to Partners In Excellence, it remains the families responsibility to work with the insurance company.

Private Pay
Partners in Excellence will enter into a Private Pay Agreement with private parties. Partners will send invoices on a monthly basis and expects that payment will be received upon receipt of the monthly invoice.

Payment in Full
In some cases a funding source may pay for only a portion of the charges. Unless specifically contracted; co-pays, discounted charges, and deductibles are the responsibility of the insured. Partners In Excellence will prepare a statement with outstanding charges due on a monthly basis and payment is due from this statement upon receipt of the statement. Insurance companies often discount rates to a "usual and customary" price. Unless contracted, Partners In Excellence does not accept discounted rates.

Partners In Excellence accepts checks, money orders, and Credit/Debit Cards (Visa, MasterCard, and Discover) for payments. Declined payments will incur an additional fee of $25.00 that will be added to your bill. We accept Visa, Mastercard and Discover Card as credit card payment for all services rendered. Credit card charges may apply as follows: Payments of up to $500.00 will have no assessed fee and any charges over $500.00 will be assessed the applicable service charge.

Payment Plans are available to clients who are unable to pay their bill on time. Please contact our billing department to arrange a payment plan.

Delinquent Accounts
An account is considered past due when payment is not received 30 days from the statement date. If other written arrangements have been agreed to, the arrangements need to follow the written agreement. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency. Legal costs and attorney's fees incurred in collecting delinquent accounts will be the responsibility of the person responsible for the account. Additionally, any account that is over 30 days past due may result in services being put on hold and/or late fees.

Financial Agreement (Page 2 of 3)

If the insurance company does not pay your balance in full within 30 days, we will ask that you contact your insurance company to help facilitate the processing of this payment. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to contact us so we can assist you in the management of your account.

Secondary Insurance
Partners In Excellence will bill a secondary insurance in the same manner as a primary insurance source. In all cases, Partners In Excellence will bill the primary insurance first and the secondary insurance once Partners In Excellence has obtained the Explanation of Benefits (EOB) from the primary insurance.

Missed and Late Therapy Appointments Fees, Holiday Survey Fees
Partners does all of the schedule changes for the entire staff by 8:00 am and therefore it is critical that all reported absences are documented by 7:30 am, or a half hour prior to your child's start time.
Daily schedule changes are as follows:

- Calling your child in sick for the part/full day absence
- Calling your child in for a doctor's appointment for a portion of the day
- Calling in to inform staff that you are running late.

Daily schedule changes must be called in to the CAL line before 7:30 am, or a half hour prior to your child's start time, to prevent a $20.00 schedule change fee. When a schedule change is called in to the CAL, a ***specific*** arrival/departure time must be given to ensure staff availability. **Any schedule changes after the designated time will result in a $20.00 schedule change fee that will be billed to the parents.**

**Partners will not assess a $20.00 schedule change fee for children that Partners sends home sick.

If you have been surveyed as to which days around a holiday you plan on bringing your child to Partners, and at the last minute change your commitment and do not bring your child to Partners on the surveyed days, you will be charged a $50 surveyed-day cancellation fee. This fee will be applied to each day originally surveyed. If your child is sick you will be charged unless a doctor's note is provided to Partners for each day surveyed.

Chronic absenteeism and tardiness will have a negative effect on your child's therapeutic progress and may result in termination of services.

Divorce Decrees
Partners In Excellence will not enter into any disputes between parents who have separated or divorced. One parent must agree to be the person responsible for the child's account.

Interest and Late Charges
Partners In Excellence reserves the right to charge interest up to the amount allowed by law (currently 18%) for late payments.

Consequences for Non Payment
Partners In Excellence reserves the right to discharge your child from therapy or suspend therapy for unpaid services or accounts that are delinquent. If services are terminated or suspended; your child is placed on the waiting list and may begin services after the account is paid in full and payment for future services is established.

Financial Agreement (Page 3 of 3)

My signature indicates that I have received a copy of Partners In Excellence's Financial Agreement and I have read and understand that I am responsible for my child's account and agree to pay for services as indicated in this agreement. I understand that I am financially responsible for all the charges whether or not paid by insurance. I hereby authorize Partners In Excellence to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Printed Childs Name

Parent/Guardian/Legal Representative Signature **Date** **Printed Name**

Parent/Guardian/Legal Representative Signature **Date** **Printed Name**

Client Rights and Responsibilities (*parent copy, please keep*)

Partners in Excellence believes in treating children and their families with respect and dignity. We are also committed to abiding by the laws and public policies, which govern relationships between consumers and agencies providing health services.

Client Rights

Partners in Excellence acknowledges that the clients and their families have the following rights:

- You have the right to participate in the development and evaluation of the services provided to your child.
- You have the right to have services provided in a manner that respects and takes into consideration the culture, religion, ethnic practices, and preferences of your child and family.
- You have the right to refuse or terminate services and be informed of the consequences of reusing or terminating services.
- You have the right to a coordinated transfer to ensure continuity of care when there will be a change in provider.
- You have the right to know, in advance, whether services are covered by insurance, government funding, or other sources, and be told of any charges the child or other private party may have to pay.
- You have the right to access records about your child in accordance with applicable state and federal law, regulation, or rule.
- You have the right to receive treatment free of maltreatment.
- You have the right to receive services in a clean and safe environment.
- You have the right to be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation.
- You have the right to file a complaint or grievance. The grievance plan is located in the Parent Handbook.

Client Responsibilities

As a client of Partners In Excellence, your responsibilities include:

- You are responsible to be clear and direct about your child and his/her disability or developmental delays. It is important for you to provide complete and accurate information about your child's medical history, medications and any other matters relating to your child.
- You are responsible to understand your child's treatment plan and follow all recommendations by the clinical team.
- You are responsible for payment of the services you receive.
- You are responsible for keeping your scheduled appointments. If your child cannot keep an appointment, please advise us as soon as your can. We recognize that children get sick unexpectedly and miss scheduled appointments. Partners In Excellence does reserve the right to discharge your child when three out of four consecutive appointments are missed without advance notice. Therefore, you must advise scheduling as soon as possible whenever your child is unavailable for a scheduled appointment.
- You are responsible for respecting the right of privacy and confidentiality of other clients in our center. This is especially true of other clients you meet and observe when participating in group situations.
- You are responsible to help us assure that our therapy center feels safe and all are protected. Partners In Excellence reserves the right to terminate service with individuals who engage in abusive language or behavior, any form of harassment or who are perceived to be under the influence of alcohol or drugs.
- You are responsible to understand all documents that you place your signature on for approval or agreeance.

Cultural Demographic Information

To enable us to meet reporting regulations for our medical agreement, we ask that you complete this form. This information is to be given voluntarily and will be used solely for reporting purposes. Refusal to provide information will not result in any adverse treatment. Your cooperation is appreciated.

Race/Ethnic Category – Please indicate ONE Race/Ethnic group you most strongly identify yourself as. The groups are as defined by the Equal Employment Opportunity Commission:

Race

- ☐ **Asian** (not Hispanic or Latino) A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example Cambodia, China, India , Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- ☐ **Black or African American** (not Hispanic or Latino) All persons having origins in any of the black racial groups of Africa
- ☐ **American Indian or Alaskan Native** (not Hispanic or Latino) A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliations or community attachment.
  - ☐ Upper Sioux
  - ☐ Mille Lacs Band of Ojibwe
  - ☐ Bois Forte
  - ☐ Grand Portage Band of Chippewa
  - ☐ Leech Lake Band of Ojibwa
  - ☐ Lower Sioux
  - ☐ Prairie Island
  - ☐ Red Lake Band of Chippewa
  - ☐ Shakopee-Mdewakanton Sioux
  - ☐ White Earth Band of Ojibwe
  - ☐ Fond du Lac Band of Lake Superior Chippewa
  - ☐ Unable to Determine
  - ☐ Not a Tribe Member
- ☐ **Native Hawaiian or other Pacific Islander** (not Hispanic or Latino) A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- ☐ **White** (not Hispanic or Latino) All persons having origins in any of the original places of Europe, North Africa, or the Middle East.
- ☐ **Unable to Determine**
- ☐ **Wish not to provide information**

Ethnicity

- ☐ **Hispanic or Latino** – All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish Culture or origin, regardless of race.
- ☐ **Not Hispanic or Latino**
- ☐ **Unable to Determine**

Residential Status

- ☐ Home with family/extended family
- ☐ Foster Care
- ☐ Residential Facility
- ☐ Homelessness
- ☐ Other _____

Supplementary Service Interest Form

Client Name_____ **Date**_____

Occupational Therapy

☐ Yes, I would like my child to receive Occupational Therapy services at Partners in Excellence.
- ☐ Currently receiving services at: _____
- ☐ Previously received services at: _____
- ☐ Has not previously received Occupational Therapy

☐ No, I do not want to enroll my child in Occupational Therapy services at Partners in Excellence.
- ☐ Currently receiving services at: _____
- ☐ Previously received services at: _____
- ☐ Has not previously received Occupational Therapy

Speech Therapy

☐ Yes, I would like my child to receive Speech Therapy services at Partners in Excellence.
- ☐ Currently receiving services at: _____
- ☐ Previously received services at: _____
- ☐ Has not previously received Speech Therapy

☐ No, I do not want to enroll my child in Speech Therapy services at Partners in Excellence.
- ☐ Currently receiving services at: _____
- ☐ Previously received services at: _____
- ☐ Has not previously received Speech Therapy

Feeding Therapy

☐ Yes, I would like my child to receive Feeding Therapy services at Partners in Excellence.
- ☐ Currently receiving services at: _____
- ☐ Previously received services at: _____
- ☐ Has not previously received Feeding Therapy

☐ No, I do not want to enroll my child in Feeding Therapy services at Partners in Excellence.
- ☐ Currently receiving services at: _____
- ☐ Previously received services at: _____
- ☐ Has not previously received Feeding Therapy

Individual (Child) Psychotherapy/Family Therapy

☐ Yes, I would to add Psychotherapy services for:
- ☐ my child ☐ our family at Partners in Excellence.
- ☐ Currently receiving services at: _____
- ☐ Previously received services at: _____
- ☐ Have not previously received Individual (Child)/Family Psychotherapy

☐ No, I do not want to add individual or family psychotherapy services at Partners in Excellence at this time
- ☐ Currently receiving services at: _____
- ☐ Previously received services at: _____
- ☐ Has not previously received Individual (Child)/Family Psychotherapy

Feeding Intake Questionnaire

(Optional if interested in Feeding Therapy)

Feeding History

Does (or did) your child gag on any foods? ☐ yes ☐ no
If yes, describe which foods: _____

Has your child ever had a swallow study (x-ray, endoscopy, etc) and/or any other FI tests? ☐ yes ☐ no
If yes, list the results: _____

Are you or your pediatrician concerned about your child's height or weight gain? ☐ yes ☐ no
If yes, explain the concerns: _____

Does your child have a history of any of the following (circle all that apply):

- ☐ Food refusal behavior
- ☐ Overstuffing his/her mouth
- ☐ Difficulty chewing
- ☐ Coughing or choking during meals
- ☐ Taking too large/too small bites
- ☐ Difficulty swallowing
- ☐ Other: _____

Does your child have any sensitivity to touch around his face, mouth, or hands? ☐ yes ☐ no
If yes, please explain: _____

Please list your child's taste and temperature preferences:

- ☐ Salty
- ☐ Sweet
- ☐ Spicy
- ☐ Tart
- ☐ Bland
- ☐ Hot
- ☐ Warm
- ☐ Cold
- ☐ Cool

Please describe your child's appetite:

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Varies from day to day

Please list food and/or other allergies:

_____

_____

Please list child's favorite foods:

1. _____
2. _____
3. _____

Please list child's least favorite foods:

1. _____
2. _____
3. _____

Please list goal foods:

1. _____
2. _____
3. _____

Informed Consent for Restrictive Procedures

This document is to inform parents that in **very rare** circumstances, a client may need to be physically restrained due to serious risk of harm to self or others. During these situations, staff members who are certified to use Nonviolent Physical Crisis Intervention℠ will be called in to assist to help de-escalate, and as a last resort, intervene to restrain client or transport client to a safe environment or both. This training is to minimize the risk of physical harm.

a. Definition of self-harm- if a client is placing herself or himself in a situation where she or he may get seriously hurt, trained staff will act to prevent child from harming self. Situations where client may place self in harm's way may include but is not limited to: running from building, or into rooms where there are dangerous items with which the client might use to climb to dangerous heights, objects that can be used for significant self-injurious behaviors, etc. A client may also be deemed at risk of harming his or herself if engaging in self-injurious behaviors such as excessive head banging, biting self, scratching self, excessive hair pulling, etc.
b. Definition of harm to others- if a client attempts to harm others including staff or clients, trained staff will act to prevent child from harming others. Situations where client may place others in harm's way may include but is not limited to: hitting, kicking, biting, using objects to harm others, or is threatening others and has history of following through on such threats, etc.
c. If a client is destroying property, verbal and non-verbal techniques will be the first choice to respond. The only time Nonviolent Physical Crisis Intervention℠ would be used is when the destruction of that property places the client at-risk of self-harm and using the destroyed items to harm someone else. For example, if a client is attempting to break glass, this would be a time to intervene as serious injury may result from broken glass.
d. If a child runs away or bolts usual ABA approaches using physical prompts to return the child to the expected area will be used. If, however, the client is highly dys-regulated and there is a risk of the client runs outside of the building which places the client at risk of being harmed by traffic or other situations, then Nonviolent Physical Crisis Intervention℠ would be implemented to reduce the risk of harm.

Parents will be informed if this intervention has been required. If a pattern begins to emerge of a child needing physical restraints, a meeting will be held with parents to review treatment plan and interventions to determine the best way to interrupt this pattern.

_____	_____
Printed Name	Name of Client
_____	_____
Parent Signature	Date

Health Insurance Portability and Accountability Act Privacy Notice (HIPAA)

(Parent Copy)

This notice describes how Partners In Excellence (Partners) uses and discloses your medical and other identifying Protected Health Information (PHI). In addition, this notice describes your legal rights in regards to your records, and the process for accessing your records. Please review this notice carefully.

As part of providing services, Partners In Excellence will collect PHI about your child's health care and your family. Partners In Excellence needs this PHI to provide quality services and to comply with certain legal requirements. This notice applies to all records generated by Partners In Excellence. This law requires us to:

- Make sure that records with identifying PHI are kept private;
- Give you this notice of our legal duties and privacy practices with respect to PHI; and
- Follow the terms of the Privacy Notice that is currently in effect.

How Partners May Use and Disclose PHI

Listed below are a number of reasons or ways in which Partners In Excellence may disclose PHI. In each category, there is an explanation of the reason and usually an example. This notice does NOT LIST EVERY USE OR DISCLOSURE IN A CATEGORY. The reasons Partners In Excellence might disclose PHI includes:

- **For Treatment:** Partners In Excellence may disclose PHI to Partners In Excellence personnel or outside of Partners In Excellence to others who are involved in providing care to you or your child. For example, Partners In Excellence Senior Therapists meet weekly to discuss challenging behaviors and programming and may share PHI at that time. In addition, with written consent, Partners In Excellence may communicate with your child's County Case Manager.

- **For Payment:** Partners In Excellence may use and disclose PHI so that services may be billed and payment may be collected from an insurance company or a government health program. Partners In Excellence may also tell your health plan about a service your child may receive to obtain prior approval or to determine whether your health plan will cover the treatment. As legal guardians, you must provide informed consent for Partners In Excellence to release this PHI.

- **For Health Care Operations:** Partners in Excellence may use Partners In Excellence to run our program and to make sure Partners In Excellence is providing quality services or to decide if services should be changed or modified.

- **As Required by Law:** Partners In Excellence will disclose PHI when required by federal, state, or local law. For example, state law requires Partners to report suspected abuse or neglect to the proper authorities, which will require the release of PHI. This use of PHI does not require consent.

- **To Avoid a Serious Threat to Health or Safety:** Partners In Excellence may use or disclose PHI when necessary to prevent a serious threat to your child's health and safety or the health and safety of the public or another person. As legal guardians, you will have the opportunity to provide written consent for this use of PHI.

- **Military and Veterans:** If you are a member of the armed forces, Partners In Excellence may release PHI about you as required by military command authorities without additional consent.

- **Workers' Compensation:** Partners In Excellence may release PHI for workers' compensation or similar programs when required by law to do so. For example, if you are involved in a claim for workers' compensation benefits, Partners In Excellence may release PHI requested about your child's health.

- **Health Oversight Activities:** Partners In Excellence may disclose PHI to a health oversight agency for activities authorized by law. Examples are government audits, investigations, inspections and licensure.

- **Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, or if there is a lawsuit or dispute concerning our services or someone who provided services to you, Partners In Excellence may disclose PHI in response to a court or administrative order. Partners In Excellence may also disclose PHI in response to a subpoena, discovery request, or other lawful process from someone else involved in the dispute, but only if efforts have been made to inform you about the request prior to providing the PHI to allow you to obtain an order protecting the PHI requested.

- **Law Enforcement:** In certain situations, Partners In Excellence may release PHI to law enforcement officials. For example, Partners In Excellence might release PHI about you to identify or locate a missing person; about a death at Partners In Excellence that may be the result of criminal conduct; or in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description of location of the person believed to have committed the crime.

- **Coroners, Medical Examiners and Funeral Directors:** Partners In Excellence may release PHI to a coroner or medical examiner to identify a deceased person or determinate a cause of death. Partners In Excellence may release PHI to funeral directors as necessary to help them carry out their duties.

- **National Security and Intelligence, Protective Services for the President and Others:** Partners In Excellence may release PHI to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

- **Correctional Programs:** If you are an inmate or in the custody of a law enforcement officer, Partners In Excellence may release PHI to the correctional institution or law enforcement official, to protect your health and safety or the health and safety of others.

Your Rights and Your Child's Rights Regarding Your Protected Health Information

As legal guardians for your child, you have the following rights:

1. To Inspect and Copy Partners In Excellence Service Records: Usually this includes medical and billing records but may exclude psychotherapy notes. To inspect and copy PHI in your record you must submit a request in writing to the Chief Executive Officer or HIPAA Compliance Officer. Partners In Excellence is allowed to charge a reasonable fee for the costs of copying, mailing or other costs related to your request.

In very limited circumstances Partners In Excellence may deny your request. If Partners In Excellence denies your request you may ask that the denial be reviewed. Another licensed health care professional of Partners In Excellence will then review your request and either uphold the original decision or reverse it.

2. To Amend Your Records. If you believe that the PHI Partners In Excellence has about you and/or your child is incorrect or incomplete; you may make a written request to the HIPAA Compliance Officer to amend the PHI. You must include a reason that supports your request.

Partners In Excellence may deny the request if it is not in writing or does not include reasons to support the request. Partners In Excellence may also deny your request if you ask us to amend PHI that:

- was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
- is not part of the PHI kept in our file;
- is not part of the PHI you would be permitted to inspect and copy or
- Partners In Excellence believes the PHI is accurate and complete.

If you disagree with the denial, you may submit a statement of disagreement. If you request an amendment to your record Partners In Excellence will include your request in the record, whether the amendment is accepted or not.

3. To Receive an Accounting of Disclosures: Partners In Excellence will keep a log of disclosures made on or after April 13, 2003, other than disclosures for treatment, billing or health care operations. You have the right to request the list of disclosures. You must submit a written request to the HIPAA Compliance Officer. The request may not cover more than a six-year period.

4. To Request Restrictions: You may request a restriction on the disclosure of PHI for treatment, payment or health care operations. Your request must be in writing to the HIPAA Compliance Officer. Your request must clearly state 1) what PHI is to be limited 2) whether you want to limit our use, our disclosure or both; and 3) to whom you want the limit to apply. For example, you could ask that Partners In Excellence not use or disclose PHI to a certain person about services your child has received.

Partners In Excellence does not have to agree to your request to restrict access to PHI. If Partners In Excellence does agree, Partners In Excellence will comply with your request unless the PHI is needed to provide emergency treatment or to comply with a lawful and legal request or investigation.

5. To Request Alternative Ways to Communicate: You may request that Partners In Excellence communicate with you about services in a certain way or at a certain location. For example, you can ask that Partners In Excellence contact you only at work, or only by mail. Your request must be in writing, must tell us how you would like us to communicate with you, and must be sent to the HIPAA Compliance Officer. Partners In Excellence will accommodate all reasonable requests.

6. To Receive a Paper Copy or Electronic Copy of this Notice: You have the right to receive a paper or an electronic copy of this notice from the HIPAA Compliance Officer.

Additional Rights Under State Law: State privacy laws may provide additional privacy protections. Any such protections will be attached in a separate State addendum to this Notice.

Changes to this Notice: Partners In Excellence may change this notice in the future. Partners In Excellence can make the revised or changed notice effect for PHI Partners In Excellence already have about you as well as any PHI Partners may create or receive in the future.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the HIPAA Compliance Officer or with the Secretary of Health and Human Services. All complaints must be in writing. Partners In Excellence will not retaliate against you for filing a complaint.

Client Release Form

Parent(s), this form allows information about your child to be exchanged. Please sign and return it to Partners In Excellence.

Client's Full Name _____ Date of Birth: _____

Parent Name _____

Address _____

I authorize Partners In Excellence to: _____Release information to: _____Obtain information from: (check either or both, as needed)

_____

Name, Title

_____

Organization Phone # Fax #

_____

Address City State Zip Code

_____ Official school records	_____ Hearing Report	_____ Speech Report(s)
_____ Health record	_____ Vision Report	_____ Occupational Reports (OT)
_____ Psychological Report	_____ Physical Therapy Report	_____ Verbal Consultation/Observation
_____ Medical Reports (including related services)	_____ ABA Report(s)	_____ Other _____

The purpose of the request: _____

Send/Fax information to Partners In Excellence:

☐ North St. Paul:	☐ Burnsville:	☐ Minnetonka:	☐ La Crosse	☐ Winona
2344 Helen Street. N	14301 Ewing Ave S,	5501 Feltl Road	901 Caledonia Street	910 E. 2nd Street
North St. Paul, MN 55109	Burnsville, MN 55306	Minnetonka, MN 55343	La Crosse, WI 54603	Winona, MN 55987
Phone: 651-773-5988	Phone: 952-746-5350	Phone: 952-746-0222	Phone: 608-785-4100	Phone: 507-474-4840
Fax: 651-773-5978	Fax: 952-746-6131	Fax: 952-746-0992	Fax: 608-785-4101	Fax: 507-474-4890

I understand that this authorization takes effect the day that I sign it. It expires on _____ or no more than one year from the date of my signature.
I also understand that I may change this authorization at any time. No more than one year from the date of my signature.
I also understand that I may cancel this authorization at any time. A cancellation will not change releases that happen before the cancellation date.
Partners In Excellence will not restrict my treatment if I choose not to sign this authorization. A photocopy fax of this authorization will be treated in the same way as the original. Partners In Excellence cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization you release Partners In Excellence from any and all liability resulting from a redisclosure by the recipient. By signing this authorization I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on me signing this authorization. Your signature indicates that you have read and understand this form and authorize release of your information as described above.

_____ _____

Parent Signature Date

Informed Consent for Mental Health Services

Partners In Excellence (Partners) provides Intensive Early Intervention Behavior Therapy to children diagnosed with an Autism Spectrum Disorder, employing a combination of Applied Behavior Analysis (ABA) and a subspecialty of ABA called Applied Verbal Behavior (AVB), and using a combination of one-to-one therapy, structured group therapy, social skills training, and family training to advance treatment goals. Additional services such as individual psychotherapy and/or family psychotherapy may be utilized as needed. The Assessment of Basic Language and Learning Skills-Revised (ABLLS-R) is used as the primary baseline assessment tool along with other assessments to identify problem skill areas and as the treatment planning guide to determine the treatment goals.

I understand that I will be notified of significant intervention changes to be implemented for my child such as a Behavior Reduction Plan (BRP) and that they are subject to my approval. Furthermore, I understand that I will be given a copy of the BRP outlining the procedures used. I understand that for the maximum benefit of my child, my participation is essential. I understand that I am expected to (a) attend meetings concerning my child, and (b) practice therapy procedures that are taught to me by Partners In Excellence staff members so that my child's skills will generalize across environments, and (c) I also understand that if I do not attend trainings and generalize these procedures at home my child's progress may be limited.

I understand that the behavioral techniques that are used at Partners may not produce observable results during the course of time in which my child attends Partners. The applications of these techniques have proven beneficial for other children on the Autism Spectrum and Partners expects similar results for my child. I understand, however, that my child may or may not benefit. Each child's response to ABA therapy is unique; most make progress, many children make significant progress, while a small number may show little progress. In addition, my child may experience behavioral difficulties during and following time with Partners. All efforts will be made to prevent, eliminate and minimize such behaviors.

_____ _____

Parent Signature Date

_____ _____

Printed Name Name of Client

Sunscreen Permission

Name of Child: _____

Children are often given the opportunity to go outside to play on playground equipment or go on short walks. Children will be dressed appropriately for the weather. In cold weather, children will be required to wear hats, mittens, and boots if appropriate. In warmer weather, staff will apply sunscreen to clients going outdoors for more than 15 minutes. Children with a history of bolting may not be permitted to go outside due to safety concerns.

o ___ As the parent/guardian of the above mentioned child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. Therefore, I **give permission** for the staff at Partners In Excellence to apply sunscreen (provided by Partners in Excellence).

o ___ Partners staff have permission to ONLY use the brand/type of sunscreen that I have provided.
Note: If your child does not have his/her own sunscreen, he/she will not be allowed to go outside.

o ___ My child does not need to wear sunscreen.

Parent/Guardian's Name: _____ **Date:** _____

Parent/Guardian's Signature: _____

NOTE: DO NOT RELY ON SUNSCREEN ALONE TO PROTECT CHILDREN FROM SKIN CANCER!
You may also send in hats and sunglasses to help protect your child.

REGISTRATION FORM

Client Information			
First name	Last name		Middle Initial
Street Address			
City		State	Zip Code
Gender: ❍ M ❍ F	Age	Date of Birth	Diagnosis

Primary Insurance			
Name of Primary Insurance Company			
Contract #	Group #		ID #
Insurance Policy Holder		Relationship to Client	
Date of Birth	Employed by		Occupation
Business Address		Business Phone	

Secondary Insurance			
Name of Secondary Insurance Company			
Contract #	Group #		ID #
Insurance Policy Holder		Relationship to Client	
Date of Birth	Employed by		Occupation
Business Address		Business Phone	

Medical Assistance (Tefra) (Write "N/A" if your child does not have Medical Assistance)
Your Child's MA number
Has your child completed the SMRT process? Yes ☐ No ☐

Assignment and Release

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Partners In Excellence all medical benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by insurance. I hereby authorize Partners In Excellence to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Parent/Guardian/Responsible Party _____Date _____

Medical Evaluation

***** This form must be completed and signed by a medical professional

Client's name:		Date of Birth:	
Most Recent Medical Exam	Date of the exam:	Name of Provider:	Provider's National Provider Identifier:
Provide details about the medical professionals' examination and evaluation of the client's physical health in the spaces provided:			

Hearing and Vision:		Complete only for abnormal findings	
		Date of follow up test:	Results or comments:
Audiology Screen:	☐ within normal limits ☐ outside of normal limits		
Vision screen:	☐ within normal limits ☐ outside of normal limits		

Genetic Testing:	Reason:	Details about Abnormal Findings:
Genetic Testing (e.g., chromosomal microarray, Fragile X):	☐ Completed – No abnormalities ☐ Completed – Abnormalities notes ☐ Not Completed – No concerns ☐ Not Completed – Other Reason	

Medical Concerns:	Findings:	Follow up Date:	Medication trials?	Results/comments:
Seizure disorder:	☐ no concern ☐ concerns noted			
Attention problems:	☐ no concern ☐ concerns noted			
Sleep concerns:	☐ no concern ☐ concerns noted			
Digestion problems:	☐ no concern ☐ concerns noted			
Elimination problems:	☐ no concern ☐ concerns noted			
Nutrition concerns:	☐ no concern ☐ concerns noted			
Depression concerns:	☐ no concern ☐ concerns noted			
Other concern:	List area of concern:			

Does the client regularly take prescription medication(s)?
☐ Yes. Submit a current medication list with this document.
☐ No.

Name of Medical Provider (Print):	Signature of Medical Provider:	Date Signed: