Treatment Consent

This document describes the nature of the agreement for professional services, the agreed upon limits of those services, and rights and protections afforded under the Behavior Analyst Certification Board's Guidelines for Responsible Conduct of Behavior Analysts. I will receive a copy of this document to retain for my records.

I, _____, agree to have my child, _____ participate in applied behavior analysis (ABA) assessment and/or treatment services provided by Superior Behavioral Services. I understand that the specific activities, goals, and desired outcomes of these ABA services will be fully discussed with me, and that I will have the opportunity to ask for clarification prior to signing this document. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation.
My insurer also has rights regarding the services that are being provided and all services and types of services may be subject to approval from my insurer. I also understand that my child is the primary client of the behavior analyst and that services will be designed primarily for my child's benefit. Any other individuals or agencies (e.g., siblings, family, day-care providers) who may be affected by the ABA services are considered secondary clients.

Right of refusal. I reserve the right to withdraw at any time from these services and I understand that such a withdrawal will not affect my child's right to services. In addition, I reserve the right to refuse, at any time, the treatment that is being offered.

Confidentiality. I understand that the procedures and outcomes of all assessment and treatment services are strictly confidential and will be released only to agencies or individuals specifically designated by me in writing. In addition, the fact that my child receives any services is protected and private information. I am aware that Superior Behavioral Services may release information without my prior consent if so ordered by a court of law. I am also aware that providers are legally required to report suspected occurrences of child abuse or neglect or if I or my child present clear and present danger to ourselves or to others. I understand that my child's assessment and treatment services may be observed by supervisors or other employees as part of ongoing training and quality assurance activities.

Authorization to bill insurance. I authorize Superior Behavioral Services to submit claims on my behalf and to release any medical or other information necessary to process my claims.

These policies have been fully explained to me, and I fully and freely give my consent and permission for my dependent.

_____
Parent/Guardian (Print)

_____ _____
Parent/Guardian (Signature) Date

Treatment Consent

This document describes the nature of the agreement for professional services, the agreed upon limits of those services, and rights and protections afforded under the American Counseling Association's Guidelines for Responsible Conduct of Certified Counselors. I will receive a copy of this document to retain for my records.

I, _____, agree to have my child, _____ participate in Mental Health Evaluation and treatment services provided by Superior Behavioral Services. I understand that the specific activities, goals, and desired outcomes of these services will be fully discussed with me, and that I will have the opportunity to ask for clarification prior to signing this document. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation. My insurer also has rights regarding the services that are being provided and all services and types of services may be subject to approval from my insurer. I also understand that my child is the primary client of the therapist and that services will be designed primarily for my child's benefit. Any other individuals or agencies (e.g., siblings, family, day-care providers) who may be affected by the services are considered secondary clients.

Right of refusal. I reserve the right to withdraw at any time from these services and I understand that such a withdrawal will not affect my child's right to services. In addition, I reserve the right to refuse, at any time, the treatment that is being offered.

Confidentiality. I understand that the procedures and outcomes of all assessment and treatment services are strictly confidential and will be released only to agencies or individuals specifically designated by me in writing. In addition, the fact that my child receives any services is protected and private information. I am aware that Superior Behavioral Services may release information without my prior consent if so ordered by a court of law. I am also aware that providers are legally required to report suspected occurrences of child abuse or neglect or if I or my child present clear and present danger to ourselves or to others. I understand that my child's assessment and treatment services may be observed by supervisors or other employees as part of ongoing training and quality assurance activities.

Authorization to bill insurance. I authorize Superior Behavioral Services to submit claims on my behalf and to release any medical or other information necessary to process my claims.

These policies have been fully explained to me, and I fully and freely give my consent and permission for my dependent.

_____

Parent/Guardian (Print)

_____ Date _____

Parent/Guardian (Signature)

Emergency Contact Form

Child Name _____ DOB _____

Address_____City _____ State _____

Phone _____

Allergies _____

_____

Contact 1

Name _____ Relationship _____

Address_____City _____ State _____

Cell Phone _____

Contact 2

Name _____ Relationship _____

Cell Phone _____

Contact 3

Name _____ Relationship _____

Cell Phone _____

_____ _____

Parent/Guardian Signature Date

HIPAA Compliance Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY BEFORE SIGNING.

Understanding Your Health Information

When you begin working with Superior Behavioral Services a record of treatment is made. Typically, this record contains your history, assessment, medical information, diagnoses, treatment, a plan for future treatment, etc. This information often referred to as you/your child's clinical record, serves as:

1. Basis for planning your care and treatment.
2. Legal document describing the care you received.
3. Means by which you or a third party payer can verify that services billed were provided
4. A source of data for health officials charged with improving the health of the nation, or needed services for the area.
5. A tool by which future or continual services can be approved.
6. Understanding what is in this record will help you to ensure its accuracy, better understand who, what, when and why others may access you information and help to make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Superior Behavioral Services the information belongs to you. You have the following rights:

A. Right to Request a Restriction

You have the right to request a restriction on our use and sharing of your protected health information. Superior Behavioral Services can deny the request if it is unreasonable or would be detrimental to your treatment.

B. Right to a Paper Copy of this Notice

You have a right to obtain a paper copy of this notice.

C. Right to Amend Your Health Information

You have the right to request an amendment to the health information we maintain about you if you feel it is incorrect or incomplete for as long as the information is kept by Superior Behavioral Services. To request an amendment, you must submit a request in writing and state the reason that supports your request. The disputed information will remain in the record along

with the amended information. may deny your request if the request is not submitted in writing, does not contain a reason to support the request, the information that is being questioned was not originated by Superior Behavioral Services, it is not part of the information which you are permitted to inspect or copy, or it is currently accurate and complete.

Health Care Insurance Providers

If we do not file your insurance claims at this time, we will provide you with statements that you may submit to your insurance carrier or complete any forms as required by your insurance carrier in order to obtain reimbursement for out-of-network providers. In order to assist you with obtaining reimbursement for our services, your insurance carrier may require that we provide a clinical diagnosis, or additional clinical information such as treatment plans or summaries, or copies of your child's entire clinical record.

In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Although all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. We will provide you with a copy of any report or form that we submit upon your request. By signing this Notice, you agree that we can provide requested information to your carrier for authorization of services and if/ when you choose to file a claim for any services that we have provided to you or your child.

Others We May Share Your Information With

As required by law we will disclose you/your child's protected health information, even if you do not sign an authorization form, under the following circumstances:

1. Disaster Relief-to an agency organizing disaster relief efforts.
2. Public Health Activities-such as: reporting to a public health or government authority or preventing or controlling disease, injury, or reporting child abuse or neglect.
3. Food and Drug Administration (FDA)-concerning adverse events or problems with products or medications for tracking purposes to enable product recalls or to comply with other FDA requirements.
4. To notify a person who may have been exposed to a communicable disease or may otherwise be at-risk of contracting or spreading a disease or condition 5. For certain purposes involving workplace illnesses or injuries.
6. Reporting victims of abuse, neglect or domestic violence-information will be disclosed as required by law.
7. Judicial and Administrative proceedings-information may be disclosed in response to a court or administrative order, subpoena, discovery requests, or other lawful process. Efforts will be made to notify you about the request or to obtain an order or agreement protecting the information.

8. Health oversight activities-information may be disclosed to a health oversight agency for activities authorized by law, such as, audits, inspections, investigations, licensure actions or other legal proceedings.

9. Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations.

10. To avert a serious threat to health or safety-any disclosure would be made only to someone able to prevent the threat of safety to you/your child, the public or another person.

11. Research-only under your specific disclosure.

12. Workers Compensation.

13. Law Enforcement-as required by law to comply with reporting requirements including, but not limited to: complying with court orders, warrants, subpoenas, summons, identifying or locating a fugitive, missing person or material witness, when information is requested about the victim of a crime if the individual agrees, to report information about a suspicious death, to provide information about criminal conduct occurring at the agency, or information about emergency circumstances about a crime.

14. National Security and Intelligence Activities, Protective Services for the President and others.

Records

We will review all testing results during our meetings with parents/guardians and offer you opportunities to review raw testing data with us. You will receive a written report that summarizes our findings. This report will include a summary and interpretation of all individual testing, as well as impressions from individual observations and consultations conducted as a part of a comprehensive, individual behavioral evaluation. Upon your request, we are happy to provide you with a written summary of our impressions from other meetings, consultations, or observations as well. We will forward copies of any reports or written summaries to others only with specific, written consent from you. Because of the proprietary nature of testing materials, we will release raw testing data only to other appropriately credentialed professionals (except as otherwise required by law).

Legal Proceedings

If you are involved in a court proceeding and a request is made for information concerning our professional services, we cannot provide any information without your written authorization or a court order. However, a court order may force us to reveal information. In that case, we will reveal only the minimally acceptable amount of information. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. Also, if a client files a complaint or lawsuit against anyone affiliated with Superior Behavioral Services, we may disclose any and all relevant information regarding that client we deem necessary in order to defend ourselves.

Confidentiality, Records, and Release of Information

Behavioral services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions and as mandated by Superior Behavioral Services and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

To Protect the Client or Others from Harm

If we have reason to suspect that a minor, elderly, or person with a disability is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions, which could include but not limited to, notifying the police or an intended victim, a minor's parents, or others who could provide protection, or seek appropriate hospitalization.

Professional Consultations

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

Your Authorization is Required for Other Uses of Protected Health Information

Superior Behavioral Services will use and disclose protected health information (other than described in this Notice or required by law) only with your written authorization. You may revoke your authorization to use or disclose protected health information in writing, at any time.

If you revoke your authorization, we will no longer use or disclose your protected health information for the purposes covered by the authorization except where we have already relied on the authorization.

Our Responsibility Regarding You/Your Child's Protected Health Information

is required by law to:

1. Maintain the privacy of your health information.
2. Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you if we are unable to agree to a requested restriction.
5. Inform you promptly if a breach occurs that may have compromised the privacy

or security of your information.

We reserve the right to make changes to this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. Any changes made will affect the protected health information we maintain at that time. We will provide a revised copy of the notice to parents/legal guardians upon request on or after the effective date of revision.

WE WILL NOT USE OR DISCLOSE YOU/YOUR CHILD'S PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION, EXCEPT AS DESCRIBED IN THIS NOTICE.

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our office. If you believe your privacy rights have been violated, you may file a complaint at our service location either in person or by mail.

CONSENT

All information is private and not shared with any outside parties. Agreement of Informed Consent and the HIPAA Privacy Policy described above and the information below must be completed before any services can be provided.

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

_____

Parent/Guardian (Print)

_____ _____

Parent/Guardian (Signature) Date

Diversity and Inclusion Policy

PURPOSE

The purpose of this policy is to explain Superior Behavioral Services and Learning Academy's commitment to making sure every member of our school community, regardless of their background or personal attributes, is treated with respect and dignity. SBS/SLA strives to provide a safe, inclusive, and supportive school environment for all students and members of our school community.

POLICY

Definitions: ***Personal attribute***: a feature of a person's background or personal characteristics that is protected by State or Commonwealth anti-discrimination legislation. For example: race, disability, sex, sexual orientation, gender identity, religion etc.

Inclusion and diversity

Superior Learning Academy is committed to creating a school community where all members of our school community are welcomed, accepted, and treated equitably and with respect regardless of their backgrounds or personal attributes such as race, language, religious beliefs, gender identity, disability, or sexual orientation so that they can participate, achieve, and thrive at school.

Superior Learning Academy acknowledges and celebrates the diversity of backgrounds and experiences in our school community, and we will not tolerate behaviors, language or practices that label, stereotype or demean others.

Superior Learning Academy will:

- ensure that all students and members of our school community are treated with respect and dignity
- ensure that students are not discriminated against and where necessary, are accommodated to participate in education and all school activities (e.g., schools sports, concerts, Eisteddfod, presentation evening) on the same basis as their peers
- acknowledge and respond to the diverse needs, identities, and strengths of all students
- encourage empathy and fairness towards others
- challenge stereotypes that promote prejudicial and biased behaviors and practices

 contribute to positive learning, engagement, and wellbeing outcomes for students.

Bullying, harassment, and other forms of inappropriate behavior targeting individuals because of their personal attributes will not be tolerated in our school community. Students who may have experienced or witnessed this type of behavior are encouraged to speak up and to let their teachers, parents or carers know about those behaviors to ensure that inappropriate behavior can be addressed.

Superior Learning Academy prohibits racially divisive symbols in our school. Superior Learning Academy will take appropriate measures to respond to discriminatory behavior or harassment at our school.

Superior Learning Academy also understands that it has a special obligation to make reasonable adjustments to accommodate students with disabilities. A reasonable adjustment is a measure or action taken to assist all students to participate in their education on the same basis as their peers. Reasonable adjustments will be made for students with disabilities through our Student Support Group processes in consultation with the student, their parents or carers, their teachers and if appropriate, their treating practitioners.

Permission to Physically Restrain for Safety

Physical restraint procedures will ONLY be used by Superior Behavioral Services when the physical safety of the child and/or others are in immediate danger. No physical restraint should be administered in such a manner that prevents a child from breathing and/or speaking. The restraint will be stopped as soon as the child is able to have a safe body.

Physical restraints may be used only when a student's behavior presents a clear, present and imminent risk to the physical safety of the student or others, and it is the least restrictive intervention feasible. Certain maneuvers and techniques are prohibited, and mechanical or chemical restraints may not be used. If it is reasonably anticipated that a restraint may be used with a student with a disability, it must be included in the student's Plan of Care.

Please sign below acknowledging you have read and understand our restraint policy.

_____ _____

Child's Name DOB

_____ _____

Parent/Guardian Signature Date

COVID Policy

Dear Families,
As you are aware, the COVID-19 also known as the Coronavirus has resulted in public health emergency in Wisconsin. As a result, we are reevaluating our policies and procedures to do everything we can to maintainthe health and safety of the children and staff in our center. We understand everyone works in a different environment and encounters many people throughout the day. I also know that we don't always know when we are sick, but still can be contagious.

We ask that you support our program by agreeing to:

1. Stay home if you are sick or become exposed to the Coronavirus.
2. Keep your child home if they are sick or become exposed.
3. In effort to stay open and keep everyone safe, we will increase our cleaning and sanitization procedures of our classrooms. We already practice handwashing, but we be diligent in helping your child wash thoroughly and frequently and sanitize toys and other play materials daily.
4. Notify staff as soon as possible if you become aware that your child or anyone in your home has been exposed to the Coronavirus.

We will do our best to limit your child's exposure risk while at the office with us, staff have all agreed to refrain from coming to work if they are sick or have been exposed. If at any time you feel it is no longer safe to have your child attend sessions at the office, we will suspend services for them at that time.

Name of Child _____

Name of Parent/Guardian _____

Signature _____ Date _____

Video Policy

We use photographs and videos for a number of reasons including celebrating and recording children successes. These images or videos may be used to communicate with parents/guardians.

I give consent for you to record and use images or videos of my child in the following ways (check all that apply):

- ☐ As a tool to monitor and track progress
- ☐ Video Modeling
- ☐ As a form of communication with parents/guardians
- ☐ Training purposes

In addition I confirm that:-
Superior Behavioral Services will take all steps to ensure images and videos are used solely for the purposes they are intended. If you become aware that these are being used or shared inappropriately, please contact Superior Behavioral Services.

Name of Child _____

Name of Parent/Guardian _____

Signature _____ Date _____

Permission to Transport

Child's Name: _____ DOB: _____

I authorize the staff at Superior Behavioral Services to transport my child as needed for services and safety.

1. I hereby release, waive, discharge and covenant not to sue Superior Behavioral Services, or its individual employees (hereinafter referred to as releasees) from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by my minor child or any of the property belonging to me, as result of, or in any way arising out of my child traveling in a vehicle not owned by Superior Behavioral Services during a treatment session provided by Superior Behavioral Services.
2. I voluntarily assume full responsibility for any risks of loss.
3. I further hereby agree to indemnify and hold harmless the releasees from any loss, liability, damage or costs due to my child traveling in a vehicle not owned by Superior Behavioral Services.
4. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed and enforced in accordance with the laws of the state of Wisconsin.
5. In signing this release, I acknowledge and represent that I have read the foregoing Waiver of Liability and Hold Harmless Agreement, understand it and sign it voluntarily as my own free act and deed.

_____

Parent/Guardian (Print)

_____

Parent/Guardian (Signature) Date

Attendance Policy

Regular attendance is an essential part of successful and effective therapy. Regular attendance can assist clients in reaching goals and maintaining gains in treatment. The following attendance policy reflects the needs of the client as well as the needs of your therapist.

1. 24 hours notice by phone is expected for cancellations. We understand that circumstances arise and that late cancellations are unavoidable. Three 'late cancels' or no call no shows in thirty calendar days will result in discussions about continuance of services.

- No call no show is defined as no call or text prior to pickup. Children will have 5 minutes from the time a staff member arrives to be ready and in the vehicle. Staff members will leave after 5 minutes if no contact is made and/or children are not ready and in the vehicle.

2. If there is consistently a pattern of poor attendance, you and your therapist will review your individual circumstance and clinical needs. All options will be considered including continuing treatment, termination from services or altering therapy schedule.

_____

Client(s)

_____

Parent Name (Printed)

_____

Parent Signature

Authorization to Release Information

Client Name:_____ DOB:_____

I understand this release is voluntary and applies to all programs and services operated under the auspices of Superior Behavioral Services. I understand that my personally identifiable information (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment, or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. I understand that I may revoke this authorization at any time by notifying Superior Behavioral Services in writing but if I do, it will not have any effect on any actions taken before recent of the revocation.

I hereby authorize Superior Behavioral Services to: (check all that apply)

☐ Exchange with ☐ Release to ☐ Obtain from

_____

Name of Organization/Individual

☐ Verbally only ☐ In written form only ☐ Verbal and in writing

Description of information to be exchanged / released / obtained:

☐ Education records

☐ Medical Records

☐ Clinical records

☐ Evaluation/assessment/eligibility records

☐ Other: _____

The purpose of this release is: _____

_____

Print name and relationship of representative to Client

_____

Signature of Client Parent/Guardian Date

Authorization to Release Information

Client Name:_____ DOB:_____

I understand this release is voluntary and applies to all programs and services operated under the auspices of Superior Behavioral Services. I understand that my personally identifiable information (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment, or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. I understand that I may revoke this authorization at any time by notifying Superior Behavioral Services in writing but if I do, it will not have any effect on any actions taken before recent of the revocation.

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☐ Exchange with ☐ Release to ☐ Obtain from

_____

Name of Organization/Individual

☐ Verbally only ☐ In written form only ☐ Verbal and in writing

Description of information to be exchanged / released / obtained:

☐ Education records

☐ Medical Records

☐ Clinical records

☐ Evaluation/assessment/eligibility records

☐ Other: _____

The purpose of this release is: _____

_____

Print name and relationship of representative to Client

_____

Signature of Client Parent/Guardian Date

Authorization to Release Information

Client Name:_____ DOB:_____

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I hereby authorize Superior Behavioral Services to: (check all that apply)

☐ Exchange with ☐ Release to ☐ Obtain from

_____

Name of Organization/Individual

☐ Verbally only ☐ In written form only ☐ Verbal and in writing

Description of information to be exchanged / released / obtained:

☐ Education records

☐ Medical Records

☐ Clinical records

☐ Evaluation/assessment/eligibility records

☐ Other: _____

The purpose of this release is: _____

_____

Print name and relationship of representative to Client

_____

Signature of Client Parent/Guardian Date