ABA Service Agreement and Consent Form

Instructions, please read the entire document carefully, the purpose of the consent is to inform about the risks and benefits of behavior therapy, and for you to have all the necessary elements to make an informed decision of whether to consent or not to consent to services.

The following document contains information regarding the provision of Applied Behavior Analysis (ABA) services provided by Skill Solutions, LLC. All services provided by Skill Solutions, LLC. are delivered by individuals who are licensed or credentialed, or by individuals who are supervised by a licensed or credentialed professional. Skill Solutions, LLC. are subject to the law and ethics of numerous governing bodies, including the Behavior Analytic Certification Board (BACB).

Demographic Information

Member’s Name:

Date of Birth:

Insurance Name:

Insurance Number:

Address (Where the recipient lives):

Parent/Legal Guardian Name:

Phone Number:

E-mail:

Diagnosis:

Applied Behavior Analysis (ABA) Services

ABA services are designed to reduce/eliminate challenging or maladaptive behavior and teach new replacement behaviors. This is done by changing the client’s environment. This includes, training and teaching parents, siblings, teachers, paraeducators, etc., how to interact with the individual, and creating more support systems in the environment. Additionally, all behaviors (including maladaptive ones) serve a function or a purpose. It is very common for challenging or maladaptive behaviors to increase in duration, intensity, and/or frequency during the beginning of treatment, because the individual wants to obtain the reinforcement that was associated with the behavior. Assessment in the beginning stages of treatment will be aimed at identifying the function of the behavior, to create a treatment plan, as well as behavior reduction and skill acquisition goals. Data collection will be utilized throughout this process and used to make programming decisions.

Confidentiality

You are entitled to privacy regarding the pursuit of ABA services for yourself and/or your children. This means your clinician cannot share, without your express written permission, that you are working with Skill Solutions LLC. There are, however, some exceptions to this. Limits to confidentiality include the following items:

1. Skill Solutions LLC is required by law to report to the authorities the following circumstances: Suspected past, current, or the possibility of future child abuse/neglect. Suspected past, current, or the possibility of future viewing/dissemination of child pornography. Suspected past, current, or the possibility of future elder/dependent adult abuse/neglect. If the client is a danger to himself/herself or if Skill Solutions LLC has knowledge that the client is a danger to someone else. If a report must be made, Skill Solutions LLC will make all efforts to include the client/parent/legal guardian in this process; however, understand that this is not always possible. Skill Solutions LLC is committed to working through whatever issues that may arise because of a legally mandated report.

2. If you are utilizing your health insurance to pay for services, the insurance company may require Skill Solutions LLC to disclose information regarding your treatment to determine whether they will pay for services, or whether they will reimburse you for services.

3. At times, it may be beneficial for Skill Solutions LLC to collaborate with other individuals you/your child are working with, e.g., psychiatrists, physicians, and/or other collateral service providers. If it appears that collateral service provider information would inform your child’s treatment, Skill Solutions LLC will obtain a signed release from you so that we may collaborate with this/these individual(s).

4. In the treatment of children, it is very helpful for Skill Solutions LLC to collaborate with teachers, speech therapists, occupational therapists, etc. to best serve your family. Skill Solutions LLC will consult with you regarding any releases that seem appropriate, as well as discuss the nature and scope of any information shared.

Insurance Funded Services

Insurance companies that are not self-funded are legally required to cover ABA services for an individual who has a diagnosis of Autism Spectrum Disorder (ASD) if the services are determined to be medically necessary. Therefore, most insurance companies require proof of ASD diagnosis, data collection on goals, progress reports, and questionnaires completed by the family. ***Failure to complete insurance requirements in a timely manner may results in a lapse of ABA services. Furthermore, it is the family’s responsibility to notify Skill Solutions LLC if there are upcoming changes to an insurance policy with as much notice as possible.***

Important Information for Parents

1. ABA services are typically authorized in 6-month periods; however, insurance companies vary in the amount of time that is typically authorized. Skill Solutions, LLC. highly recommends agreeing to and scheduling all hours the funding source authorizes; failure to do so makes it difficult to request an increase in hours in the future if an increase is needed.

1. A family member or other designed caregiver over the age of 18 must be present for all ABA services.
2. Families will be given as much notice as possible for staffing changes. Families can discuss staffing changes with the Clinical Director.
3. If there is a cost to deliver services in the community (i.e. parking fee, entrance fee, etc.) than the family will have to pay for the Skill Solutions, LLC staff to be there. Families are never expected to pay for food or drinks for staff.
4. You will be responsible for the payment of fees for services provided by Skill Solutions, LLC in the event of services not covered by insurance and including insurance co-pays and deductibles.
5. You have the right to stop treatment at any time.
6. We understand that circumstances, such as illness or family emergency, may arise which necessitates the occasional cancellation of appointments. To avoid any misunderstanding, our policy is for a client or family to contact the supervisor directly to cancel or re-schedule session(s). Excessive cancellations by a client/family may result in termination of services, as consistency of the delivery of services as proposed in a treatment plan is critical. We ask that you attempt to give at least 12 hours of notice when canceling or rescheduling an appointment.

Summary of the Florida Patient’s Bill of Rights and Responsibilities

Patient Right’s

1. A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
2. A patient has the right to receive a prompt and reasonable response to questions and requests.
3. A patient has the right to know who is providing medical services and who is responsible for his or her care.
4. A patient has the right to know what patient support services are available, including if an interpreter is available if he or she does not speak English.
5. A patient has the right to know what rules and regulations apply to his or her conduct.
6. A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
7. A patient has the right to refuse any treatment, except as otherwise provided by law.
8. A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
9. A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
10. A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
11. A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
12. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
13. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
14. A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
15. A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

Patient Responsibilities

1. A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
2. A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
3. A patient is responsible for reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
4. A patient is responsible for following the treatment plan recommended by the health care provider.
5. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
6. A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
7. A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
8. A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Authorization for Disclosure of Health Information

In Accordance with HIPAA Privacy Regulations,

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize my provider to disclose my protected health information (PHI) to their designated Network of Providers for the purpose of facilitating continued care, care coordination, or case management.

The Network of Providers may re-disclose this information only to other affiliated providers who are directly involved in my care or care management.

Information to Be Disclosed

By signing this authorization, I consent to the release of all health information contained in my provider’s records, including but not limited to:

* Billing and insurance information
* Authorizations for treatment
* Case management documentation
* Utilization management records
* Grievance and complaint records
* Member service documentation
* Any additional documents relevant to the provision or coordination of care

I understand and acknowledge that the disclosed information may include sensitive health data such as mental health treatment, behavioral health records, and related diagnoses.

Acknowledgments

I understand and acknowledge that the disclosed information may include sensitive health data such as mental health treatment, behavioral health records, and related diagnoses. I understand that I can cancel (revoke) this authorization at any time by submitting a written request to my provider. Canceling this authorization will not affect any information that was shared before the provider received my request. Unless I cancel it, this authorization will stay in effect until my child’s services have ended. I understand that my decision to sign or not sign this authorization will not affect my child’s ability to receive treatment, payment, enrollment, or eligibility for benefits. I understand that once my child’s health information is shared, the person or organization receiving it might share it again, and it may no longer be protected by federal privacy laws. I understand that if I choose not to sign this authorization, Skill Solutions, LLC. may not be able to offer certain services—especially if they cannot verify my insurance coverage or get the approvals needed to begin services.

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| Parent/Legal Guardian Name: | Signature:  | Date:  |