**INITIAL & ANNUAL CONSENT TO PARTICIPATION**

INDIVIDUAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BEHAVIOR ANALYST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expectations for Participation**

To achieve the best possible outcomes for the individuals we serve, we believe it is essential to fully engage and empower families and other caretakers to carry interventions over into homes, schools, and communities. Instead of simply providing direct services, much of our work occurs in collaboration with others supporting the individual. As a partner in this process, you are agreeing to work closely with us and assume mutual responsibility for the individual’s success. That means communicating with us regarding your goals, needs and challenges. It also means taking an active role in the process. Specifically, you agree to:

* 1. Communicate with members of the individual’s support team (e.g., teachers, therapists)
	2. Gather information to track the individual’s behavior and circumstances surrounding it (e.g., data collection)
	3. Help us to design a behavior support plan that is feasible for you and your family/agency
	4. Actively participate in the coaching sessions to practice the support plan strategies
	5. Make your best effort to implement the strategies on an ongoing basis, providing the behavior analyst feedback on the plan’s effectiveness
	6. Participate in evaluating our program by responding to caregiver surveys when administered

 Initials: \_\_\_\_\_\_\_\_\_\_

**Settings/Participants**

Intervention is most effective when developed based on patterns across all settings in which there are concerns and involving support providers in those settings. Please complete the following table on the locations in which you would like the assessment and subsequent intervention to occur. Please provide the address and names of participants in each setting and circle **yes** or **no** to indicate your consent to access these sites and individuals.

|  |  |  |  |
| --- | --- | --- | --- |
| **Location** | **Address** | **Participants** | **Consent** |
| Home |  |  | Yes No |
| School |  |  | Yes No |
| Other |  |  | Yes No |

We do our best to schedule services around the needs and preferences of our clients. What days and times would work best for you?

|  |  |
| --- | --- |
| [ ]  Monday Hours:  | [ ]  Friday Hours:  |
| [ ]  Tuesday Hours:  | [ ]  Saturday Hours:  |
| [ ]  Wednesday Hours:  | [ ]  Sunday Hours:  |
| [ ]  Thursday Hours:  |  |

Maintaining the safety of our clients and contractors is critical to service delivery. For this reason, our behavior analysts and assistants will not enter nor work in environments that pose significant risks; these include settings with environmental hazards (e.g., weapons, dangerous chemicals, broken glass, infestations, unsafe structures, etc.) or in which the residents or participants are using narcotics or engaging in violent or threatening behavior. Contractors may utilize an environmental safety checklist to identify potential risks prior to beginning services.

Initials: \_\_\_\_\_\_\_\_\_\_

**Release of Records**

In order to complete a comprehensive assessment and ensure that our services are coordinated with other program supporting the client, we may need access to the following records:

[ ] Insurance information [ ] Psychological or educational assessments
[ ] Individualized plans (IFSP, IEP) [ ] Progress notes or quarterly/annual reports
[ ] Previous behavior programs [ ] Psychosocial histories
[ ] Medical evaluations Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that information received by Beacon of Hope and Behavior Consultation may include confidential medical data, including psychiatric and/or drug and alcohol usage and references to blood-borne pathogens (e.g., HIV, AIDS). I understand that I may revoke this consent at any time; however, I cannot revoke consent for action that has already been taken and therefore the records may have already been reviewed by Beacon of Hope and Behavior Consultation staff. This consent automatically expires 30 days after terminating services. Beacon of Hope and Behavior Consultation will adhere to HIPAA Privacy and Security Standards in accessing and storing confidential information and will ask you to sign a release and update it annually.

I hereby authorize the release of this information from the individuals listed on the preceding page, as well as the following (please provide names and addresses):

|  |  |  |
| --- | --- | --- |
| Name | Address | Phone |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Initials: \_\_\_\_\_\_\_\_\_\_

**Confidentiality**

Maintaining strict confidentiality of client assessment and intervention information is a particular concern for Beacon of Hope and Behavior Consultation staff. Beacon of Hope and Behavior Consultation will maintain records at both 1504 Andres Avenue Ozark AL 36360 and electronically.

Records may only be accessed by authorized personnel and will be protected via locked file cabinets and encrypted passwords on computers. No information related to an individual who is receiving services, either verbal or written, will be released to other agencies or individuals without the express written consent of the individual’s legal guardian.

By law, however, the rules of confidentiality do not pertain under the following conditions.

1. If abuse or neglect of a minor, disabled, or elderly person is reported or suspected, the professional involved is required to report it to the local law enforcement office or child welfare office for investigation.
2. If, during the course of services, the professional involved receives information that someone’s life is in danger, that professional has the duty to warn the potential victim.
3. If our records and staff testimony are subpoenaed by court order, we are required to produce records or appear in court to answer questions regarding the individual.
4. If you choose to break confidentiality by sharing private information through conversations or an unsecured communication medium (e.g., email, telephone), Beacon of Hope and Behavior Consultation cannot be held liable for the outcome.

Initials: \_\_\_\_\_\_\_\_\_\_

**Payment for Services**

Payment for our services is expected to occur in a timely manner. If paying privately for services, a written agreement the fees and billing schedule will be established. Insurance and Medicaid coverage is subject to eligibility and availability of funds (e.g., policy lapses and deductible renewal). Once our services begin, if at any time the client becomes ineligible for Medicaid or insurance, it is your responsibility to notify Beacon of Hope and Behavior Consultation to postpone or cancel services until eligibility has been restored. Hours billed to Medicaid or insurance that are not reimbursed due to ineligibility will be directly billed to the parent/guardian/individual and will become their responsibility. Payment plans are available.

It is inappropriate for our independent contractors to accept money or gifts from clients. Therefore, Beacon of Hope and Behavior Consultation strongly discourages parents/guardians/individuals from offering behavior analysts or behavior assistants any additional rewards, including, but not limited to cash, gift cards, gas money, tickets or admission to events, or any other costly items.

If an analyst or assistant is asked to go to an event as part of therapy, it is the responsibility of the parent/guardian/individual to pay for the admission to the event. Cost of meals will be the responsibility of the analyst or assistant.

Initials: \_\_\_\_\_\_\_\_\_\_

**Cancellation Policy**

Regular attendance is required for our services to be effective. Irregular attendance costs both the assigned staff member and overall program time and money. It is therefore the responsibility of the individual and his or her legal guardian to attend and participate fully in all scheduled appointments. It is expected that caregivers will be present at all times, unless otherwise specified on the behavior support plan (e.g., for community outings).

If you are unable to make a scheduled appointment, please contact your staff person immediately. If you reach the staff member an hour or more prior to your scheduled appointment, it will be considered a “cancellation.” If you cancel immediately prior to your appointment or are not present when the staff member arrives, it will be considered a “no show.” If you no show or cancel more than twice in one month, your assigned staff member will contact you to explore options for improving attendance such as a change in schedule. If you cannot be reached or the pattern of cancellations or no shows continues, your services will be discontinued. You will receive a letter from Beacon of Hope and Behavior Consultation confirming termination. Services can only be resumed if you provide a written request offering a resolution of the barriers to consistent attendance.

Initials: \_\_\_\_\_\_\_\_\_\_

**Surveys and Reports**

It is our priority at Beacon of Hope and Behavior Consultation to ensure that we are providing you and your family with the highest quality of services. In order for us to monitor this, we will be sending out *Caregiver Surveys* on an annual basis. It is important that you fill out the survey and send it back to us in order for us via email, fax, or mail in order for us to address any areas of need so that we may continue to improve our service delivery.

 Initials: \_\_\_\_\_\_\_\_\_\_

**Crisis Management**

Given the nature of the challenges individuals who participate in our services face, it is not uncommon for an individual to engage in behavior that puts him/her or others at risk. If this occurs, the crisis will be managed using the least intrusive and safest strategies to curtail the behavior. Beacon of Hope and Behavior Consultation makes every effort to avoid provoking this type of behavior unnecessarily and to respond quickly to address problems as soon as they arise (e.g., through prompting communication, presenting choices or assistance, clarifying expectations, or using redirection). If the individual becomes aggressive or self-injurious, these behaviors may be managed by blocking strikes, removing the person or others, changing the surroundings, or restraining the individual briefly using an approved crisis management procedure and in accordance with chapter 65G-8, section 393.13 If the caregivers and staff are unable to manage the behavior safely, they will call 911 and/or seek assistance from another professional. If medical attention is required, the parent/guardian/caregiver will need to provide transportation. Specific crisis management procedures will be incorporated into the individual’s behavior support plan.

Initials: \_\_\_\_\_\_\_\_\_\_

**Discharge Process**

Beacon of Hope and Behavior Consultation reserves the right to discontinue services or discharge individuals from their services under the following conditions:

1. Individual achieves all of his or her established goals and the parent/caregiver/individual agrees that graduation from services is warranted
2. Parent/primary caregiver/individual refuses to follow the mutually agreed upon treatment plan after repeated reminders and attempts to resolve barriers to implementation
3. Individual ages out of coverage (e.g., at the individuals 21st birthday and/or no longer enrolled in school). Note: this applies to ABA therapy through insurance and Medicaid only; other rules vary based on funding source.
4. Individual is not achieving the goals of treatment despite exhaustion of all known interventions, procedures, and research-based strategies.
5. Beacon of Hope and Behavior Consultation staff become aware of circumstances (e.g., drug abuse, illegal activities, hostile behavior of caregivers) that may place them at risk
6. Individual, parent, or guardian decides to terminate services for any reason

If at any time Beacon of Hope and Behavior Consultation or the parent/guardian/individual determines that services must be terminated, we will notify the other party immediately and establish a discharge plan to be provided to the parent/guardian/Individual within 14 business days. If a client is discharged from Beacon of Hope and Behavior Consultation, it is the policy of our agency to provide a list of other providers and professionals in the area with the background and expertise to provide effective support services to the client and their family. Our staff does not provide services or recommendations outside our area of expertise.

Beacon of Hope and Behavior Consultation *will not turn down a family for coverage nor will we discharge or discontinue treatment on the basis of race, creed, sexual orientation, or socio-economic characteristics.*

Initials: \_\_\_\_\_\_\_\_\_\_

**Rights of Our Clients**

Individuals with disabilities (and behavioral challenges) have the same rights as everyone else. Beacon of Hope and Behavior Consultation embraces the Bill of Rights for the Developmentally Disabled and does everything in its power to uphold these rights. These rights specify that individuals and their families must be treated with dignity and that behavioral procedures must be explained in user-friendly terms. This Bill of Rights is attached and will be reviewed with parents/guardians/individual during intake and annually, obtaining signatures to indicate acknowledgement and understanding.

Please indicate which right is most important to you: (***Please write below***)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individuals also have the right to be free from abuse. If someone suspects that an individual is being abused or neglected, this should be reported to the abuse hotline at the following number:

 **1-800-962-2873**

Initials: \_\_\_\_\_\_\_\_\_\_

**Infectious Disease Reporting**

Beacon of Hope and Behavior Consultation adheres to state and federal guidelines outlined by the department of health in reporting confirmed and suspected cases of infectious disease(s). If any member of Beacon of Hope and Behavior Consultation’s team – or a caregiver - suspects or confirms infectious disease in an individual, they are obligated to report it to their local or regional health department at the following number:

([334) 774-5146](https://www.google.com/search?q=Alabama%20health%20department&oq=Alabama+health+department+&aqs=chrome..69i57j0l5.8514j0j8&sourceid=chrome&ie=UTF-8&npsic=0&rflfq=1&rlha=0&rllag=31382497,-85496407,36640&tbm=lcl&rldimm=10663767587358670199&ved=2ahUKEwiEyeXZhuPjAhVEQ6wKHRyhDoIQvS4wAnoECAYQNQ&rldoc=1&tbs=lrf:!2m1!1e2!2m1!1e3!2m1!1e16!3sIAE,lf:1,lf_ui:2" \o "Call via Hangouts)

Initials: \_\_\_\_\_\_\_\_\_\_

**Grievance Procedures**

Beacon of Hope and Behavior Consultation makes every effort to meet the needs of its clients and be responsive to concerns. If you are not satisfied with the services you are receiving from the staff assigned to you, please first address your concerns with the behavior analyst assigned to your client. We will investigate the concern thoroughly within 30 days and propose a solution. Grievances and their resolutions will be documented and maintained in the client files.

Initials: \_\_\_\_\_\_\_\_\_\_

**Risks and Benefits**

Participating in any treatment has numerous benefits, but also certain inherent risks. For example, individuals receiving services from Beacon of Hope and Behavior Consultation may experience disruptions in daily life (e.g., due to professionals entering the setting or suggesting changes in routines), stress associated with identifying problematic patterns or learning to respond differently to the individual’s behavior, or frustration at delays in progress or the necessity to modify approaches periodically. These are, of course, in addition to risks to privacy and confidentiality that occur when sharing information. Beacon of Hope and Behavior Consultation will make every effort to minimize these risks and make services optimally beneficial and enjoyable.

Initials: \_\_\_\_\_\_\_\_\_\_

**Acknowledgement and Consent**

I certify that I have authority to legally consent to assessment, release of information, and all legal issues involving \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Upon request, I will provide Beacon of Hope and Behavior Consultation with proper documentation of guardianship. If my status as legal guardian should change, I will immediately inform Beacon of Hope and Behavior Consultation and provide the name, address, and phone number of the person(s) who have assumed that role.

I hereby acknowledge that I have received information on Beacon of Hope and Behavior Consultation’s participation expectations and policies regarding records release, confidentiality, payment, appointment cancellation, discharge, and grievance procedures and have had the opportunity to ask questions and get clarification regarding these requirements and processes. I have received a summary of the HIPAA Privacy and Security Standards, Recipient Choice and Rights, and abuse hotline number. This consent will be updated annually.

I acknowledge that accessing services through Beacon of Hope and Behavior Consultation is a choice and that I have the right to change companies or request a change in my behavior analyst, behavior assistant, mental health professional, and/or intern at any point. I provide my consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in an assessment through Beacon of Hope and Behavior Consultation in the settings I have indicated. I agree to participate fully in this process, meeting under mutually agreed upon time and place. My consent expires one year after termination of services/from the date below. I hereby agree to these terms.

PARENT/GUARDIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INDIVIDUAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BEHAVIOR ANALYST SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***THIS SHOULD REMAIN WITH THE INDIVIDUAL OR CAREGIVERS***

**Recipient Choice and Rights**

RIGHTS OF ALL PERSONS WITH DEVELOPMENTAL DISABILITIES.--The rights described in this subsection shall apply to all persons with developmental disabilities, whether or not such persons are individuals of the agency.

(a)  Persons with developmental disabilities shall have a right to dignity, privacy, and humane care, including the right to be free from sexual abuse in residential facilities.

(b)  Persons with developmental disabilities shall have the right to religious freedom and practice. Nothing shall restrict or infringe on a person's right to religious preference and practice.

(c)  Persons with developmental disabilities shall receive services, within available sources, which protect the personal liberty of the individual and which are provided in the least restrictive conditions necessary to achieve the purpose of treatment.

(d)  Persons with developmental disabilities shall have a right to participate in an appropriate program of quality education and training services, within available resources, regardless of chronological age or degree of disability. Such persons may be provided with instruction in sex education, marriage, and family planning.

(e)  Persons with developmental disabilities shall have a right to social interaction and to participate in community activities.

(f)  Persons with developmental disabilities shall have a right to physical exercise and recreational opportunities.

(g)  Persons with developmental disabilities shall have a right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse, or neglect.

(h)  Persons with developmental disabilities shall have a right to consent to or refuse treatment, subject to the provisions of s. [393.12](http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0393/Sec12.HTM)(2)(a) or chapter 744.

(i)  No otherwise qualified person shall, by reason of having a developmental disability, be excluded from participation in, or be denied the benefits of, or be subject to discrimination under, any program or activity which receives public funds, and all prohibitions set forth under any other statute shall be actionable under this statute.

(j)  No otherwise qualified person shall, by reason of having a developmental disability, be denied the right to vote in public elections.

Beacon of Hope and Behavior Consultation

1504 Andrews Ave

Ozark, AL 36360 855-432-2543

**COORDINATION OF CARE FORM**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Coordinate:** I \_\_\_\_\_\_\_\_Parent Name\_\_\_\_\_\_\_\_\_\_ give permission for Beacon of Hope and Behavior Consultation to contact you for Coordination of Care and medical and treatment records marked below for the patient listed above.

Thank you, \_\_\_\_\_\_\_\_Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_

**Treating Provider Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The patient is being treated for the following problems:**

[ ] Mental Health Diagnosis [ ] Chronic Illness [ ]  Occupational Therapy (OT)

[ ] Medication Management [ ]  Routine Care [ ]  Physical Therapy (PT)

[ ] Substance Abuse [ ] Change in Medical Status [ ]  Speech and Language Pathologist (SLP)

[ ] Eating Disorder

[ ] Other Mental Health Issues \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expected Next Appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication(s) and Dosages**

1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant information that may impact medical or behavioral health, including hospitalizations, and any descriptions of chronic medical illness:**

*\*If you would like to discuss this client/patient’s treatment, please contact me at the number above.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Signature Date

***THIS SHOULD REMAIN WITH THE INDIVIDUAL OR CAREGIVERS***

**HIPAA Privacy and Security Standards**

## Policies and Practices to Protect the Privacy of Your Health Information (HIPPA Policy)

*THIS NOTICE DESCRIBES HOW ALL MEDICAL INFORMATION ABOUT THE CLIENTS WE SERVE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

1. **Uses and disclosures for Treatment, Payment, and Health Care Operations**

Beacon of Hope and Behavior Consultation may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent as stated on the online referral form.

To help clarify these terms, here are some definitions:

* + **PHI**–refers to information in your health record that could identify you.
	+ **Treatment**‐is when a health care professional provides, coordinates, or manages your health care and other services related to your health care.
	+ **Payment**–is when Beacon of Hope and Behavior Consultation obtains information about your healthcare benefits and eligibility and/or attempts to obtain and/or obtains reimbursement for your healthcare. Examples of payment are when Beacon of Hope and Behavior Consultation discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
	+ **Health Care Operations**–is when Beacon of Hope and Behavior Consultation discloses your PHI to your health care service plan (for example your health insurer), or to other health care providers contracting with your plan, for administration of the plan, such as case management and care coordination.
	+ **Use**–applies to activities within the Beacon of Hope and Behavior Consultation office such as sharing, applying, utilizing, examining, and analyzing information that identifies you.
	+ **Disclosure**–applies to activities outside of Beacon of Hope and Behavior Consultation office such as releasing, transferring, or providing access to information about you to other parties.
	+ **Authorization**– means written permission for specific uses or disclosure.
1. **Uses and Disclosures Requiring Authorization**

Beacon of Hope and Behavior Consultation may use or disclose PHI for purposes outside of treatment, payment, and health care operations when an appropriate authorization is obtained. In those instances when Beacon of Hope and Behavior Consultation is asked for information for purposes outside of treatment and payment operations, Beacon of Hope and Behavior Consultation will obtain an authorization from you before releasing this information. Beacon of Hope and Behavior Consultation will also need to obtain an authorization before releasing your therapy progress notes.  Therapy progress notes are notes your therapist has made about your conversation, actions, observations, etc, during an individual, group, joint or family treatment session, which are kept separate from the rest of your medical records. These notes are given a greater degree of protection of PHI. You may revoke all such authorizations of PHI at any time; however, the revocation or modification is not effective until received by Beacon of Hope and Behavior Consultation in writing.

**Uses and Disclosures with Neither Consent nor Authorization**

Beacon of Hope and Behavior Consultation may use or disclose PHI without your consent or authorization in the following circumstances:

* + **Child Abuse:** If any Beacon of Hope and Behavior Consultation Team Member knows or suspects that a child has or is being abused, abandoned, neglected, or neglected, the law requires that they report such knowledge or suspicion to the proper authorities according to the county and state you reside in.
	+ **Adult and Domestic Abuse:** If any Beacon of Hope and Behavior Consultation Team Member knows or suspects, that a vulnerable adult(disabled or elderly) has been or is being abused, neglected, or exploited, they are required by law to

immediately report such knowledge or suspicion to the local number located in the Rights of Our Clients section.

* + **Health Oversight:** If a complaint is filed and later is open for investigation; a subpoena for confidential health information from certain parties may requested and therefore shared.
	+ **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information regarding your diagnosis or treatment and the records thereof, such information is privileged under state law, and Beacon of Hope and Behavior Consultation will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform Beacon of Hope and Behavior Consultation that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
	+ **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, Beacon of Hope and Behavior Consultation. must communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

**IV.       Patients’ Rights and Therapist’s Rights:**

* + **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Beacon of Hope and Behavior Consultation is not required to agree to a restriction you request.
	+ **Right to Received Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and alternative locations. For example, you may not want a family member to know you are in treatment. Upon request, Beacon of Hope and Behavior Consultation will send your bills to another address.
	+ **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI of Beacon of Hope and Behavior Consultation’s treatment and billing records used to make decisions about you for as long as the PHI is maintained in the record. Upon your request, Beacon of Hope and Behavior Consultation will discuss the details of the request process.
	+ **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record; however Beacon of Hope and Behavior Consultation may deny your request. On your request, Beacon of Hope and Behavior Consultation will discuss with you the details of the amendment process.
	+ **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI. On your request, Beacon of Hope and Behavior Consultation will discuss with you the details of the accounting process.
	+ **Right to a Paper Copy:** You have the right to obtain a paper copy of this notice from Beacon of Hope and Behavior Consultation upon request, even if you have agreed to receive this notice electronically.
	+ Beacon of Hope and Behavior Consultation is required by law to maintain the privacy of PHI and to provide you with a notice of Beacon of Hope and Behavior Consultation’s legal duties and privacy practices with respect to PHI.
	+ Beacon of Hope and Behavior Consultation reserves the right to change the privacy policies and practices described in these notices. Unless you are notified of such changes, however, we are required to abide by the terms currently in effect.
	+ If Beacon of Hope and Behavior Consultation revises privacy policies and practices, they will make their best effort to contact you with this information in person, by telephone, by email, or by mail. For this reason, it is important that you notify Beacon of Hope and Behavior Consultation immediately of any address, telephone, or email changes.
1. **Complaints**

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Beacon of Hope and Behavior Consultation at 855-432-2543. You have specific rights under the privacy rule.  Beacon of Hope and Behavior Consultation will not retaliate against you for exercising your right to file a complaint.