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NEW CLIENT PACKET

Client Information

Full Name: _____ Date of Birth: _____

Social Security Number: _____ Gender: Male _____ Female _____

Address: _____

Diagnosis (if any) _____

Known Allergies: _____

Race (circle one): Native American/Native Alaskan * Asian * Black/African American * Native Hawaiian/other Pacific Islander * White/Caucasian * More than one race * Decline to respond

Ethnicity (circle one): Hispanic/Latino Not Hispanic/Latino Decline to respond

Preferred Language: _____

Referred By: _____

Primary Contact

Name: _____ Relationship to Client: _____

Home Phone/Cell Phone: _____

Email: _____

Address, if different from above: _____

Secondary Contact

Name: _____ Relationship to Client: _____

Home Phone/Cell Phone: _____

Email: _____

Address, if different from above: _____

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AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Keystone Behavioral Pediatrics is working to ensure that confidentiality regarding your child's medical information is maintained at all times. Because of the concern of confidentiality, we need to know if we are able to leave a message or communicate to you concerning your child's care, if unable to reach you by phone. If you agree to this, please complete the following information and indicate your preferences.

Please initial and fill in appropriate phone number or email address on all that apply:

May leave detailed message on voicemail at home #_____ Int:____

May leave detailed message on voicemail at work # _____ Int:____

May leave information with other family member (name) _____ Int:____

May leave detailed message on cell phone (provide preferred #) _____ Int:____

May correspond via email (preferred email address) _____ Int:____

DO NOT LEAVE ANY DETAILED MESSAGES ON PHONE OR EMAIL _____

With my signature below, I acknowledge and understand that this information will be kept in my medical records and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers or emails listed above. I also understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____

Signature of Guardian Date

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INSURANCE INFORMATION AND AUTHORIZATION

PRIMARY INSURANCE CARRIER:

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Insured: _____

Sponsor ID / Subscriber ID**:** _____ Group Number: _____

Insurance Name: _____ Phone: _____

Address: _____

SECONDARY INSURANCE CARRIER:

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Insured: _____

Sponsor ID / Subscriber ID**:** _____ Group Number: _____

Insurance Name: _____ Phone: _____

Address: _____

AUTHORIZATION TO RELEASE INFORMATION/PAYMENT OF INSURANCE BENEFITS: I hereby authorize Keystone Behavioral Pediatrics, LLC to furnish my insurance carrier any information acquired in the course of my evaluation or treatment that is necessary to complete my insurance forms. Also, I hereby assign to Keystone Behavioral Pediatrics, LLC all payments for services rendered. If the insurance company fails to pay Keystone Behavioral Pediatrics, LLC in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Keystone Behavioral Pediatrics, LLC. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all cost of collection, including a reasonable attorney's fee.

Parent/Guardian Print Full Name: _____

Parent/Guardian Signature: _____

Relationship to Client: _____

Date: _____

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

THIS NOTICE DESCRIBES HOW CONFIDENTIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

I. General Information

This Notice describes the privacy practices of Keystone Behavioral Pediatrics (“Keystone”). This Notice is drafted and provided to you, consistent with the requirements of the privacy rules ("Privacy Rules") of the Health Insurance Portability and Accountability Act ("HIPAA"). As a qualified health care provider, we are committed to meeting the requirements of the law to maintain the privacy of our clients’ Protected Health Information and to providing you with this Notice of your legal duties and our privacy practices relating to your Protected Health Information.

II. Our Privacy Obligations

We are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Healthcare Operations. We may use and disclose PHI, but not "Highly Confidential Information" (defined below), in order to treat you, obtain payment for equipment and services provided to you and conduct our "healthcare operations" as detailed below:

- Treatment. We use and disclose your PHI to provide treatment and other services to you. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.
- Payment. We may use and disclose your PHI to obtain payment for equipment and services that we provide to you -- for example, disclosures to claim and obtain payment from your health insurer, HMO or other company that arranges or pays the cost of some or all of your healthcare (“Your Payor") to verify that Your Payor will pay for healthcare.
- Healthcare Operations. We may use and disclose your PHI for our healthcare operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. We may also disclose PHI to your other healthcare providers when such PHI is required for them to treat you, receive payment for services they render to you or conduct certain healthcare operations, such as quality assessment and improvement activities, reviewing the quality and competence of healthcare professionals, or for healthcare fraud and abuse detection or compliance.
- Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose the client’s PHI to a family member, other relative, a close personal friend or any other person identified by the client when you are present for, or otherwise available prior to, the

disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we will disclose only information that we believe is directly relevant to the person's involvement with your healthcare or payment related to your healthcare. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

- Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe the client is a victim of abuse, neglect or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence.
- Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the healthcare system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.
- Judicial and Administrative Proceedings. We may disclose the client's PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

IV. Uses and Disclosures Requiring Your Written Authorization

For any purpose other than the ones described above in Section III, we only may use or disclose PHI granted to us by written authorization ("Authorization for PHI"). For instance, an Authorization for PHI must be completed before we can send your PHI to another doctor's office or a relative/family friend.

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state laws require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"). We will comply with such special privacy protections which may cover the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment and referral; (4) is about child abuse and neglect; (8) is about domestic abuse of an adult with a disability; or, (9) is about sexual assault.

V. Your Rights Regarding Your Protected Health Information

If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact us. You may also file written complaints with the Director, Office for Civil Rights of the U. S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with us or the Director.

- Right to Request Restrictions. You may request restrictions on our use and disclosure of your PHI, for the following reasons: (1) for treatment, payment and healthcare operations; (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care; or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. If you wish to request restrictions, please submit a written request to the Director of Practice Management at 6867 Southpoint Dr. N, Jacksonville, FL 32216, or fax to (904) 212-0309.

- Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.
- Right to Revoke Your Authorization. You may revoke any written authorization obtained in connection with your Highly Confidential Information, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Director of Practice Management at 6867 Southpoint Dr. N, Jacksonville, FL 32216, or fax to (904) 212-0309.
- Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please submit a written request to the Director of Practice Management at 6867 Southpoint Dr. N, Jacksonville, FL 32216, or fax to (904) 212-0309.
- Right to Amend Your Records. You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please send a written request for the amendment, including the reason for the amendment, to the Director of Practice Management at 6867 Southpoint Dr. N, Jacksonville, FL 32216, or fax to (904) 212-0309. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.
- Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to start of care. Keystone Behavioral Pediatrics follows Florida Administrative Code Rule **64-B8-10.003** regarding the copying of client records:
  For the first 25 pages, the cost will be $1.00 per page.
  For each page in excess of 25 pages, the cost will be $0.25.
  Please allow 7-10 days for medical records to be available for pick-up at 6867 Southpoint Drive North, Jacksonville, FL 32216.
- Right to Receive Paper Copy of This Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

This Notice is effective today.

Right to Change Terms of This Notice. We reserve the right to, meaning we may, change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas at our facility and on our Internet site. You also may obtain any new notice by contacting Keystone Behavioral Pediatrics.

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CLIENT RIGHTS AND RESPONSIBLITIES

Client's Rights

- Clients have the right to be treated with dignity and respect.
- Clients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Clients have the right to have their treatment and other client information kept private.
- Only in a critical emergency or if required by law can records be released without client permission. (Please see your right under HIPAA.)
- Clients have the right to have an easy-to-understand explanation of their condition and treatment.
- Clients have the right to know all about their treatment choices, regardless of cost or coverage.
- Clients have the right to information about providers.
- Clients have the right to know the client clinical guidelines used in providing and/or managing their care.
- Clients have the right to share in the formation of their treatment plan.
- Clients have the right to know about their rights and responsibilities in the treatment process.
- Clients and providers have the right to be treated and work in an environment that is free from any form of sexual harassment.
- Clients have the right to know how our office complies with HIPAA regulations. Please refer to our Notice of Privacy Practices located in our waiting room with a summary copy provided to each client.

Client's Responsibilities

- Clients have the responsibility to give providers the information they need to deliver the best possible care.
- Clients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Clients have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
- Clients have the responsibility to treat those giving them care with dignity and respect.
- Clients have the responsibility to keep their appointments. Clients should call their providers as soon as possible if they need to cancel visits.
- Clients have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- Clients have the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the client and provider.
- Clients have the responsibility to know the terms of their insurance policy coverage.
- Clients have the responsibility to pay for services rendered in a timely manner.

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Initial

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CONSENT FOR SERVICES

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 ethical code of conduct set forth by each discipline. This is a copy of this document to retain for my records. All fees for services and payment arrangements will be reviewed separately.

Keystone provides services from the following disciplines: Behavior Analysis, Psychology, Mental Health, Feeding, Speech and Language Pathology, Occupational Therapy, Pediatrics and Psychiatry. We recognize the importance each discipline plays on a client's team, which is why Keystone uses evidenced-based practices to create a personalized treatment plan. Evidenced-based practice integrates three basic principles: (1) the best available research evidence bearing on whether and why a treatment works, (2) clinical expertise to rapidly identify each patient's unique health state and diagnosis, individual risks and benefits of potential interventions and (3) client preferences and values. A provider can only utilize the strategies she or he has been trained to implement. If you, as a consumer, want to implement a method other than what a Keystone provider is trained for, or a method not consistent with the principles of that discipline, then you can speak with your provider to help you assess the effectiveness of the method. However, it is against Keystone policy for providers to implement these methods or any method that does not have rigorous scientific testing for outcome efficacy. Your provider can also set up a meeting with other providers to discuss the methods and strategies we CAN implement and why we suggest those specific strategies in the client's treatment plan.

I am aware other interventions I am pursuing may affect my child's response to treatment; therefore, it is important to make the team aware of those interventions and to partner with the team to evaluate any associated therapeutic or detrimental effects of those interventions.

I agree to have my child/dependent participate in assessments and/or treatment services provided by Keystone. 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 in services. I understand that my child/dependent is the primary client of Keystone and that services will be designed primarily for the client's benefit. Any other individuals or agencies (e.g., family, school professionals) that may be affected by the services are considered secondary clients.

If the services focus on increasing my child's skills, I understand that the first several sessions will consist of assessment activities designed to (a) evaluate his/her current skills (e.g., assessments) and (b) determine which strategies, interventions and treatment are likely to prove most effective. The time allocated to these assessments will result in improved intervention. I understand that the beginning of services will include assessment activities (e.g., interviews, checklists, direct observations) that are designed to provide information critical to the development of effective treatment procedures. I may be asked to assist in gathering some of this information by recording problem behavior and symptoms as they occur.

The subsequent services will be focused on development of and implementation of a plan. Prior to implementation, I will receive a printed copy of the results of any assessment and of any proposed instructional procedures or treatment plans for my approval. The contents of those documents will be explained to me fully and any questions I have will be answered to my satisfaction. Subsequent implementation will involve caregiver trainings that are important for the intervention, details about the specific components of the intervention, and direct practice in the components for the family, educators and/or other service providers. Full participation in these implementation and training activities is critical for a successful outcome.

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Ongoing collection of data will allow evaluation of the effectiveness of the intervention and will assist in developing any revisions that need to be made to ensure a good outcome. In addition, at regular progress reviews we may also discuss whether continuation of services would be beneficial and whether there are any barriers to continuation.

I understand that when a Keystone provider is present during a session, the focus needs to be on the client and implementation of the treatment plan. Communication between provider and parent/caregiver or others that are present need to be client-focused, such as reviewing progress and discussing new goals or strategies to meet goals. Similarly, when provider and consumer/client communicate outside of sessions (phone, email, etc.) communication should remain focused on the client.

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/dependent receives any services is protected and private information. I am aware that Keystone 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 when there are 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 the provider agency employs individuals at the bachelor's level who are supervised by Licensed and Certified Providers. 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. Events occurring in those sessions will be discussed in closed supervision meetings. I am aware that a record of the treatment will be maintained and this record is available to me in written form upon request.

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 the event of withdrawal, I may request a list of other credentialed providers in the region. In addition, I reserve the right to refuse, at any time, the treatment that is being offered.

I am aware that the relationship between provider and client is a professional one that precludes ongoing social relationships, giving of gifts, personal social media connections, or participation in personal events such as parties, graduations, etc.

I may request a copy of a provider's current professional credentials. In addition, any concerns may be directed to the Director of Practice Management at 6867 Southpoint Dr. N, Jacksonville, FL 32216, or call (904) 619-6071.

_____

Signature of Parent/Guardian Date

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ETHICAL STANDARDS

Although the relationship between a provider and client involves personal interactions and discussions, it is important that a professional relationship is maintained. Each discipline offered by Keystone is subject to ethical standards set forth by the governing body of that disciple. Below are examples of situations that can become ethical concerns and therefore dictate the interaction a provider can have with a client.

If you have concerns about whether a Keystone provider following ethical guidelines, please refer to the Grievance Policy on how to file a complaint. Copies of ethical guidelines are available upon request or can be found at the websites listed below.

Dual Relationships:
Guidelines require that Dual Relationships between provider and client be avoided. The relationship between the provider and the client should be a professional one, with focus on the client and his or her treatment. To prevent dual relationships from forming, the following policies have been developed.

Social Media (i.e. Facebook, Twitter, Instagram, text messaging, etc.):
It is Keystone policy that staff is not connected to active providers/active clients through social media websites including, but not limited to, Facebook, Twitter, Instagram, etc. If text messaging is the preferred form of communication for the parents, it is only to discuss scheduling and cancellations. In addition, all email communication should be client-focused. An appropriate avenue for families to be connected to Keystone staff and to find out about Keystone news and events is the Keystone Facebook page.

Gifts (birthdays, holidays, goodbyes, etc.):
In order to prevent potential dual relationships from forming, Keystone has a gift policy in place that prevents Keystone staff from accepting gifts of any type from a client. While we very much appreciate this token, it can make the provider-client relationship cloudy and difficult to prevent from turning into a dual relationship. As alternative to purchasing or creating a gift for your child's providers at holidays, consider purchasing or creating materials that will motivate your child to learn and that can be used during sessions. Along similar lines, we also cannot accept meals during sessions, even if sessions take place during scheduled meal times. Staff may bring their meals with them if needed, but cannot accept meals from a client during or outside of sessions. We have designated the third week of December for any gifts. One gift is allowed per year.

The following is a list of governing boards and the website to access each discipline's Code of Ethics:

American Medical Association
http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page

American Psychological Association
http://www.apa.org/ethics/code/

Behavior Analyst Certification Board
http://bacb.com/wp-content/uploads/2015/05/BACB_Compliance_Code.pdf

American Speech-Language Hearing Association (ASHA)
http://www.aota.org/-/media/Corporate/Files/Practice/Ethics/Code-of-Ethics.pdf

The American Occupation Therapy Association, Inc. (AOTA)
http://www.aota.org/-/media/Corporate/Files/Practice/Ethics/Code-of-Ethics.pdf

GRIEVANCE POLICY

This policy describes your recourse if, at any time and for any reason, you are not satisfied with the professional relationship between a provider and yourself/your child. When possible first discuss, verbally or in writing, with the provider within seven (7) days of the alleged grievance. If seven (7) days have passed without resolution or you are not comfortable discussing the alleged grievance directly with your provider, then notify the Director or Assistant Director of the department from which you are receiving services. The Director or Assistant Director will investigate within seven (7) days after the receipt of such grievance and make every effort to resolve the grievance to the client's satisfaction. If the grievance cannot be resolved to the client's satisfaction, the client or the client's parent/guardian is to notify the Director of Practice Management in writing. The grievance must state the problem or action alleged and the date the supervisor was notified. The Director of Practice Management will investigate the grievance in an attempt to resolve the difference and notify the client in writing of the resolution of the grievance.

Keystone Behavioral Pediatrics, LLC
(904) 619-6071
info@keystonebehavioral.com
6867 Southpoint Drive N.
Suite 101
Jacksonville, FL 32216

Mental Health:
Director: Katherine Falwell, Ph.D., BCBA-D
falwell@keystonebehavioral.com

Applied Behavior Analysis:
Director: Matt Delaney, MA, BCBA
delaney@keystonebehavioral.com

Practice Management:
Director: Julie Riley, MSW
riley@keystonebehavioral.com

Rehabilitative Medicine
Director of Occupational Therapy
RJ Navarro, OT/L, cNDT
Navarro@keystonebehavioral.com

Director of Speech-Language Pathology
Jennifer Martin, MA, CCC-SLP
jmartin@keystonebehavioral.com

Board of Speech-Language Pathology and Audiology
(850) 488-0595
http://floridasspeechaudiology.gov

Florida Board of Occupational Therapy
(850) 488-0595
http://floridasoccupationaltherapy.gov

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FINANCIAL POLICY

1. **General**
   a. The client's insurance policy is a contract between the client and his or her insurance company. Services and procedure codes associated with visits to Keystone may or may not be reimbursed by a client's insurance carrier. Therefore, as a courtesy, the client assumes total responsibility for payment of these charges. Keystone will file claims with the client's insurance company and bill the insurer for all charges. Keystone will also bill the client's secondary insurer when this complete insurance information is provided**. If a client's insurer does not pay for visits or a portion of the charges, the client understands that each client is responsible for any remaining balance on the client's account. The client understands that verification of benefits is not a guarantee of payment by an insurance company.**
   b. Client co-pays are expected at the time of service, and any remaining payment is due in full within 30 days of receiving the first bill from Keystone. We accept cash, checks, money orders and credit cards (Visa, MasterCard, Discover, and American Express).
   c. If you cannot pay your balance within 30 days, please contact our Billing Office at (904) 619-6071. There are several ways you can pay your bill, including possible payment plans. A Billing Office representative will help find the right one for your financial needs. We will also work with you to determine if you are eligible for financial assistance.

2. **Cancellation/Late Policies:**
   a. We ask that parents give 24 hours' notice for cancellations, in the form of a phone call and voicemail to (904) 619-6071 to notify the provider working with your child. Cancellations (or "no shows") without 24 hours' notice are subject to a cancellation fee of $50. The provider will bill for this $50 fee and the parent will receive a bill along with their monthly co-pay to cover this statement.
   b. Late Drop-Off (for sessions at clinic locations) - If a parent is more than 7 minutes late for the session, the parent is responsible for paying the rate of $50/hour or $1 per minute they are late. Providers will bill for this time, and parents will receive a statement.
   c. Late Pick-Up (for sessions at the clinic) – Our providers often have sessions back-to-back, so it's important that parents are on time for pick-up, in order for the next session can start on time. If a parent is more than 15 minutes late, more than twice, we reserve the right to require a parent to be on site for all sessions (if in the clinic) or ask for sessions to take place in the home. A fee of $1 per minute will be charged for late pick-up.

   Please understand that these policies are in place in order for our staff to best implement the programs prescribed for all of our clients. Often when providers have cancellations or no-shows, they have opportunities to provide needed hours for other clients. We understand that emergency situations occasionally arise for both providers and parents, and we handle these situations on a case-by-case basis. Our providers are also expected to give 24 hours' notice for cancellations and are expected to call if they will be late due to traffic or other unforeseen circumstances. If parents feel that cancellations or late sessions are becoming "excessive," please contact your provider or directly contact the office to discuss. We appreciate your understanding of the need for these policies in continuing to provide services to your children!

3. **Waiver of Co-Pays and Deductibles**
   a. It is the policy of this practice to bill all applicable out-of-pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. Keystone will not waive co-pay, co-insurance or deductible amounts for insured clients, except in the limited circumstances set forth in this Client Financial Responsibility Policy.

Such determinations may be made only after sufficient investigation has been made, and it is expected that such waivers will be *rare*.

b. If Keystone does waive co-payments or deductibles for a client based on the client's financial status, the Agency will maintain a record of the information upon which this decision was made. Waivers of co-pays and deductibles may also be made after reasonable collection efforts have failed to result in the collection of the fees. Keystone will maintain records of what collection efforts have been made for fees waived in these instances.

c. Under no circumstances will the Agency engage in any of the following practices with respect to the waiver or lowering of co-insurance and/or deductibles:

- Waive or lower co-insurance and deductibles that do not meet the requirements outlined in our Policy.
- Advertise or in any way communicate to the general public that payments from private insurance will be accepted as payment in full for health care services provided by our practice.
- Advertise or otherwise communicate to our clients or to the general public that clients will incur no out-of-pocket expenses.
- *Routinely* use financial hardship forms, which state that the client is unable to pay co-insurance and deductible amounts.
- Charge private insurance beneficiary's different amounts than those charged to other persons for similar services.
- Fail to collect co-insurance and deductibles from a specific group of clients for reasons unrelated to indigence or managed care contracting (e.g., to obtain referrals or to induce clients to seek care in our practice versus another provider's practice who does not waive co-pays and/or deductibles).
- Accept "insurance only" or TWIP (Take What Insurance Pays) as payment in full for services rendered.
- Fail to make a reasonable collection effort to collect a client's balance.

4. <u>Professional Records</u>

a. All complete records will remain on file for a minimum of seven years after the last contact with the client and, if the client is a minor, the records will be maintained until seven (7) years after the age of majority. A client may request these records at any time; however, because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. Keystone requires a completed and signed *Request and Authorization for Release of Health Information* before releasing any documents to anyone, including the patient. The form must be completed, dated and signed, and Keystone asks that you specify what components of your medical records you wish to obtain. This document is available through our front office by calling (904) 619-6071 or emailing scheduling@keystonebehavioral.com.

b. If you change insurance providers at any time during your therapy, please notify us immediately. This will enable us to send insurance claims to the appropriate location. Your estimated financial responsibility is to be paid in full. Please note that due to the individual needs of each case this fee is an estimate. Due to the constant changes that may occur regarding your deductible, we cannot reevaluate your payments if your deductible is met by another provider. All refunds, if applicable, will be issued after all insurance matters have been settled. For convenience your co-pays are due at the time of services.

5. **Past Due Balances:**
    a. A past due balance is any amount owed after the insurance company has paid or denied, and Keystone has not received the full client balance within forty-five (45) days. After forty-five (45) days as a private pay balance, interest will accrue at the rate of 5.0% per month on the unpaid balance at the discretion of the practice. This includes self-pay clients. Balances on accounts with payment plans where payments are in compliance with the plan are not considered past due balances. *Clients who have a previous collection balance and wish to receive services are required to pay any outstanding balance at the time of service.*

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SICK CANCELLATION POLICY

Due to the medical needs of our clients, we require that parents/guardians cancel or reschedule therapy sessions for the following reasons:

- Fever at or above 100°F
- Vomiting
- Sinus infections/colds with yellow or green mucus
- Conjunctivitis (pink eye)
- Lice
- Strep throat
- Chicken pox, measles, mumps, RSV, rubella, mononucleosis

Your child may begin receiving services after an illness within the below listed time periods:

- 24 hours – Must be symptom-free and receiving the necessary medications for vomiting, fever, sinus infections and colds
- 48 hours – After receiving medical treatment with antibiotics for strep throat and conjunctivitis
- 72 hours – After receiving medication treatment and having no live lice; also, following maintenance treatments as indicated on product label
- Physician's Release – Must obtain after chicken pox, measles, mumps, RSV, rubella and mononucleosis. (If for any reason your child is admitted to the hospital, you must provide a release from the Physician stating that it is okay to resume regular or limited therapy before services can be continued).

To cancel or reschedule an appointment, please contact (904) 619-6071 or email scheduling@keystonebehavioral.com .

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Psychological Assessment Policy

I understand that in order to maintain treatment integrity for my child, psychological assessments will be required for my child on a regular basis. Assessments are used as part of a comprehensive treatment plan designed to maintain appropriate instructions and goals for students. Assessments must be completed at regular intervals for multiple reasons, including to obtain updated understanding of current functioning, ensuring evidence-based treatment can take place, observing and documenting effects of therapy and medications, and documenting medical necessity for insurance companies. Without regular assessment, we do not have the necessary documentation to justify medical necessity to insurance companies and cannot guarantee continued coverage for my child's services. Additionally, many insurances **require** these assessments in order for continued coverage to be provided. When possible, a member of my child's therapy team will be present during assessment to implement the behavior plan, including providing appropriate reinforcement and managing any problem behaviors that may occur. In order to ensure continued coverage for the services my child receives, the following is required for all clients receiving therapy at Keystone Behavioral Pediatrics.

1) Yearly updates of client's cognitive and adaptive functioning
    a. _____ These assessments will consist of one session assessing my child's cognitive functioning, as well as adaptive rating scales that will be completed by me and teachers/therapists
    b. _____ I understand that this assessment must be conducted once per year to document continued medical necessity. I will be notified in advance when this assessment will take place.
2) Comprehensive psychological assessments: Psychological assessments are a comprehensive evaluation of a student's cognitive (e.g., I.Q.), academic, adaptive, social/emotional, and behavioral functioning. These evaluations are conducted by a psychologist or under the supervision of a psychologist.
    a. _____ All clients receiving therapy are required to have a comprehensive psychological evaluation on file that is current within 2 years. Re-evaluations may be requested earlier if considered necessary by the team.
    b. _____ I will be notified when my child requires a psychological evaluation and will be involved in the scheduling process if I choose to have the evaluation completed at Keystone Behavioral Pediatrics.
    c. _____ I understand that I may have the evaluation completed at Keystone Behavioral Pediatrics or by a different entity. However, I am required to have the evaluation completed within this time frame.
    d. _____ If I choose to have the evaluation completed at Keystone Behavioral Pediatrics, questionnaires will be sent home for me to fill out and for teachers to fill out (If child is at MSA, forms will be given to MSA teacher to complete). A deadline for returning forms will be provided. Failure to return forms in a timely manner will result in a late fee charge of $1.00 per day. If misplaced, replacement forms will be provided at a fee of $5.00 per form. These forms are required for an evaluation to be complete.
    e. _____ If I choose to have the evaluation completed at Keystone Behavioral Pediatrics, I may be asked to attend and be a part of one or more testing sessions. There will be a $50 fee per hour of testing appointments that are missed or cancelled with less than 24 hours' notice. Please note that every scheduled hour includes an additional hour of writing and interpretation time.

As such, a testing appointment that is missed or cancelled with less than 24 hours' notice may result in a fee of up to $200.

I hereby understand the need for updated psychological assessments as described and consent for psychological assessments to be conducted as specified in this consent.

Client's Name	Parent, Legal Guardian or Self	Date

Policy on Leaving a Child Alone During and After Completion of Session

Keystone Behavioral Pediatrics requires that a caregiver over the age of 18 be present at all times while a provider is engaged in a home session. If for some reason you or another adult caregiver is not available during the session you may submit a formal request asking that you be granted permission to leave your child alone with the provider during the session.

Keystone Behavioral Pediatrics will review each request and make a formal decision based on the family's specific needs. Exemptions include community- and school-based services.

If you are approved to leave your child alone with the provider there must be an adult over the age of 18 present no less than five minutes prior to the end of the session. Failure to comply with this regulation may result in approval being terminated and reinstating of the requirement that an adult be present at all times.

Policy on Suspected Child Abuse and Neglect: Mandated Reporting

This policy is to inform our clients and their families that Keystone Behavioral Pediatric providers are mandated reporters and, as such, have a legal obligation to report suspected child abuse or neglect. In our roles as providers, we are not trained to say whether an observed or reported incident ***is*** abuse or neglect. However, there are certain situations that we are required, by law, to report. Oftentimes, these situations are not clear, and since we don't have the training to say whether an incident ***is*** abuse or neglect, we must make a report to allow those trained in making these determinations to observe and offer support that we cannot provide. Ultimately, the goal is to ensure that our clients and families have the support that they need on all levels.

Please be aware that if a report is made, we are not making an accusation that abuse or neglect is occurring. We are, as objectively as possible, retelling a situation as it was reported or observed and allowing those professionally trained in these matters to do their jobs to ensure the safety of the child or family member(s).

If a difficult situation like this were to occur, please understand that first and foremost our priority is continued support in your child and family's life to ensure safety and wellbeing. Sometimes this involves requesting the help of other providers offering services outside of our scope. If circumstances allow, we will always try to be open and honest about our concerns. Please also understand that failure on our part to report situations may result in civil or criminal action against us.

In our experience, the best outcomes in these situations occur when families are open and cooperative in the steps that take place following a report and continue to welcome the support of Keystone's providers. We will make every effort to continue to offer our support or refer to another provider if necessary.

If you have any questions or concerns about this policy or about child abuse and neglect reporting laws, please refer to the Florida Statue, Title XLVI Crimes, Chapter 827 Abuse of Children, which can be found at http://www.leg.state.fl.us/Statutes/

If you are in need of support or services to prevent or stop child abuse or neglect, please Call Florida's Child Abuse Hotline at 1-800-96-ABUSE or go to http://www.myflfamilies.com/service-programs/abuse-hotline.

They can put you in touch with someone who can offer support and help.

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ACKNOWLEDGEMENTS AND CONSENTS

Please read carefully:
By placing my initials below, I am indicating that I have read, understand and had the opportunity to ask questions regarding any information in this packet as it pertains to my dependent or myself. I have been given a copy of each policy or consent for my reference and can request an additional copy at any time from the front office.

_____ **Health Insurance Portability and Accountability Act (HIPPA)**

_____ **Client Rights and Responsibilities**

_____ **Consent for Services**

_____ **Ethical Standards**

_____ **Grievance Policy**

_____ **Financial Policy**

_____ **Sick/Cancellation Policy**

_____ **Assessment Policy**

_____ **Policy on Leaving a Child Alone During and After Completion of Session**

_____ **Policy on Suspected Child Abuse and Neglect: Mandated Reporting**

I certify that I am the parent/guardian of the below listed client/dependent and I am entrusted to make medical decisions for my child/dependent. If any split or shared custody or shared guardianship agreement exists, I certify that I have notified Keystone Behavioral Pediatrics, LLC and the other parent/guardian(s) have consented to psychological assessments and treatment services. I understand I may be asked to provide documentation as proof before services can begin.

Client's Name (Print): _____ **Client's DOB:** _____

Parent/Guardian Full Name (Print): _____

Relationship to Client: _____

Parent/Guardian Signature: _____

Date: _____

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AUTHORIZATION TO SHARE FOR CLIENT INFORMATION

By signing below, I, as the parent or guardian of the below named child, hereby authorize Keystone Behavioral Pediatrics, LLC to share and/or discuss my child's medical information with the following individual(s):

1. _____ _____
   First and Last Name (Printed) Relationship

   ☐This individual is authorized to pick up my child in my absence.

2. _____ _____
   First and Last Name (Printed) Relationship

   ☐This individual is authorized to pick up my child in my absence.

3. _____ _____
   First and Last Name (Printed) Relationship

   ☐This individual is authorized to pick up my child in my absence.

4. _____ _____
   First and Last Name (Printed) Relationship

   ☐This individual is authorized to pick up my child in my absence.

Client's Name (Print): _____ **Client's DOB:** _____

Parent/Guardian Full Name (Print): _____

Parent/Guardian Signature: _____

Date: _____

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Consent for the Use of Behavior Management Procedures

Client's Name: _____DOB: _____

I understand that in order to maintain client safety and to provide behavioral treatment it may be necessary to use behavior management procedures that involve physical contact with my child. Interventions that are not appropriate or are ineffective based on behavioral assessment will be discontinued. The philosophy of Keystone Behavioral Pediatrics is to use the least restrictive means necessary in order to maintain safety.

"Behavior Management Procedures" are used as part of a comprehensive plan designed to safely manage clients. These procedures are classified into three categories:

1) Transport Procedures: designed to relocate clients safely when they are unwilling to move and/or they are in danger of harming themselves and others. This includes but is not limited to one/two handed escort and basket-hold escort.

2) Prompting Procedures: designed as a method to deliver instructional tasks, which may involve hand-over-hand physical guidance.

3) Response Reduction Procedures: designed to reduce target problem behaviors. This includes but is not limited to the use of chair time-out, secluded time-out room, basket-hold, and hands-down. If you are uncertain about the specifics of these procedures, please ask for a detailed description. Response reduction procedures are only used if necessary and after consultation with the caregivers.

I hereby consent for behavior management procedures to be used as specified in this consent. All of my questions about the procedures have been answered to my satisfaction.

Client's Name (Print): _____ Client's DOB: _____

Parent/Guardian Full Name (Print): _____

Parent/Guardian Signature: _____

Date: _____

Keystone Behavioral Pediatrics
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Digital Recording and Photography Policy

Client's Name: _____ **Client's DOB:** _____

I understand that my child (named above) will be digitally recorded and/or have pictures taken by Keystone Behavioral Pediatrics, LLC for educational, training, and supervision purposes; including, informal and non-standardized assessments.

Parent/Guardian Full Name (Print): _____

Parent/Guardian Signature: _____

Date: _____

Digital Recording and Photography Consent

In addition, I give permission to Keystone Behavioral Pediatrics, LLC to photograph or digitally record my child for the following:

Do Not Consent	Consent	
_____	_____	Keystone's website
_____	_____	Keystone's Facebook page
_____	_____	Brochures and promotional materials
_____	_____	Keystone's newsletter

I have read the above waiver and understand the policy. This consent will remain in effect until written authorization is provided to change or revoke permissions.

A blank form may be requested from the front office at (904) 619-6071 or by emailing scheduling@keystonebehavioral.com.

Parent/Guardian Signature: _____

Date: _____