A Balanced Alternative
Teach.Build.Create

Karly Boswell, MS, BCBA, LBA
abalancedalternative@gmail.com
www.abalancedalternative.com

14540 John Marshall Hwy
Suite 101
Gainesville, VA 20155
540.878.0263

Client Information and Contract Agreement

Client Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Overview of Services

Individual Screening:

- Upon first signing your child up with A Balanced Alternative, LLC you will receive the following to set your child up for success:
  - Parent survey
  - Sign up for initial one on one screening with Karly Boswell, BCBA
  - Overview of the social skills groups we offer
- Parent survey: consists of questions specific to your child's likes, dislikes, social skills, play skills, etc. This is a way for us to get to know your child before working with them.
- One on One session: your child will work directly with Karly Boswell, BCBA for an hour. During this hour she will work on getting to know your child's social skills level using various evidence-based assessments (VB-MAPP, PEAK, etc.)

Class Placement:

- Review of Assessments: Karly Boswell will go over the completed assessments with the parent. During this overview, she will focus on the skills addressed for class placement.
- Class Placement: A detailed overview of the class your child is placed in will be provided. This overview will include class focus, structure, and schedule.
- Sign-Up for Sessions: Based on the class appropriate for your child's level a list of available days and times will be provided. Once you sign-up for your first class you will be added to the VIP group for special events and promotions.

Weekly Sessions:

- Based on your child's group will determine the weekly skills and structure of their class.
- Play groups:
  - Early Intervention Group: Children will have the opportunity to learn in a small group through play using techniques such as modeling and facilitated play
  - School Readiness Group: Children will learn to generalize play skills into a small group and use these skills to build and develop beginner social skills such as turn taking and playing in a group.
- Social Skills Groups:
  - Early Elementary Group: Children will have the opportunity to learn basic social skills through group learning and modeling. Children will practice appropriate coping mechanisms for difficult situations.
  - Older Elementary Group: Children will begin to build on their beginner social skills and learn to generalize these skills into their community. Children will also have the opportunity to work on using appropriate coping mechanisms in difficult situations.

Progress Monitoring: An overview of each session and your child's progress will be emailed to you at the end of each class. Quarterly progress notes will also be provided.

Cancellation and Financial Policies

- If you are not able to attend your session, please contact Karly as soon as possible. Twenty-four hours is recommended for non-emergency cancellations.
- Therapy sessions must be canceled for any of the following reasons:
  1. Vomiting, temperature (100 degrees or higher), or diarrhea
  2. Persistent hacking cough with colored phlegm
  3. Colored nasal drainage
  4. Rash (unless indicated by a doctor that the rash is not contagious)
  5. Lice, pink eye, chicken pox, or other contagious conditions
  6. Therapy sessions will not resume until 24 hours after the last episode of vomiting or fever.
- All no-show appointments will be billed a $40 fee. _____ (initials)

Payment Options

- The payment for services can be done weekly or monthly. Monthly payments must be completed at the start of the month before your first session. Cash, checks made out to Karly Boswell and Venmo will be accepted. Please choose one payment option and initial the returned check fee.
  - I would like to pay weekly. _____ (initials) _____
  - I would like to pay bi-weekly. _____ (initials) _____
  - I would like to pay monthly. _____ (initials) _____
  - I understand that there will be a $30 fee for any returned checks. _____

- If you have any concerns or comments, please contact Karly as soon as possible. It is important to her to discuss your needs.

- If your child has a food allergy, please indicate them:
  _____
  There are times when snacks may be provided.

- Closures:
    - Inclement Weather: We will follow Fauquier County Public Schools closures for all inclement weather. If you are unable to make class due to your location, please let Karly know ASAP.
    - We will be closed on the following holidays:
        - January – New Year's Day
        - May - Memorial Day
        - July – Independence Day
        - September – Labor Day
        - November – Thanksgiving Day
        - December – Christmas Eve, Christmas Day
    - Other: If the office will be closed for any other reason (i.e. sickness, out of town, etc.) Karly Boswell will send out an email prior to the day of the class(es) that will be canceled.

- During our group sessions we allow parents to stay in the lobby until the end of the session. If at any time a parent is needed to assist their child for any reason, Karly Boswell will contact the parent. Otherwise, parents are asked to remain in the lobby until the end of session to allow for less distractions for all children. An overview of each session and your child's progress will be emailed to you at the end of each class. Quarterly progress notes will also be provided.

I hereby acknowledge and agree to the billing and cancellation policies.

Parent/Guardian Signature: _____ Date: _____

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Client Case History

General Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Zip Code: _____

Mother's Name: _____ Age: _____

Mother's Occupation: _____ Business Phone: _____

Mother's Email Address:
_____

Father's Name: _____Age: _____

Father's Occupation: _____Business Phone: _____

Father's Email Address:
_____

Referred By (if applicable):
_____

Primary Care Physician: _____ Phone: _____

Address:
_____

Brothers and Sisters (names and ages):
_____

What is your child's primary language?

What languages are spoken in the home? What is the primary language?

With whom does your child spend most of his/her time?

Describe your child' social strengths:

Describe your child's social difficulties:

How does your child usually communicate (gestures, signs, pictures, single words, short phrases, sentences)?

When was the problem first noticed? By whom?

Is your child aware of his/her difficulties? If yes, how does he/she feel about it?

Have any other specialists seen your child? If yes, they type of specialist, when your child was seen, and the specialist's conclusions or suggestions (you may provide reports):

Are there any other difficulties to be aware of for your child (behavioral, sensory, speech, etc.)? If yes, please describe:

Medical History

Provide the approximate ages at which your child received any medical diagnoses (i.e. autism, ADHD, etc.)

Diagnosis: _____ Age: _____

Diagnosis: _____ Age: _____

Diagnosis: _____ Age: _____

Provide the approximate ages at which your child suffered the following conditions:

Allergies _____ Asthma _____

Seizures _____ Other _____

Has your child had any surgeries? If yes, what type and when?

Describe any major accidents or hospitalizations:

Is your child taking any medications?

Have there been any negative reactions to medications? If yes, identify:

Developmental History

Provide the approximate age at which your child began to do the following activities (if applicable):

Use single words: _____
Name simple objects: _____
Use simple sentences: _____
Use simple questions: _____
Engage in conversation: _____

Educational History

School: _____
Grade: _____

Teacher(s):
_____

How is your child doing academically (or pre-academically)?

Does your child receive special services? If yes, describe:

How does your child interact with others (shy, aggressive, uncooperative, etc.)?

If enrolled for special education services, has an Individualized Education Plan (IEP) been developed? If yes, are you willing to provide a copy of goals/objectives and accomodations?

Provide any additional information that might be helpful in the evaluation or remediation of your child's problem:

Person completing form:
_____

Relationship to child:
_____

Signed: _____
Date: _____

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Liability Waiver

By registering my child with A Balanced Alternative, LLC, I hereby release A Balanced Alternative, LLC from liability for any injury that might occur to myself, child and family members while at A Balanced Alternative, LLC.

I agree to indemnify and hold harmless the above-mentioned organization and/or individuals and/or employees, against any and all liability for personal injury, or damage to my personal property, the property of my children and/or other family members, while participating with A Balanced Alternative, LLC.

Signature _____
Date _____

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A Balanced Alternative, LLC
Notice of Privacy Practices

As required by the privacy regulations creative as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A: Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at this time.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of 30 Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.

B. We may use and disclose your PHI in the following ways:

1. **Treatment:** Our practice may use your PHI to treat you. For example, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. We may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Health care operations:** Our practice may use and disclose your PHI to evaluate the quality of care you received from our business, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

3. **Appointment reminders:** Our practice may use and disclose your PHI to contact you to remind you of an appointment.

4. **Treatment options:** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

5. **Health-related benefits and services:** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

6. **Release of information to family/friends:** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you/your children.

7. **Disclosures required by law:** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

C. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use of disclose your health information:

Public health risks: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled

D. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain:

1. **Confidential communications:** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may request that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to Mary Kay Yates.
2. **Requesting restrictions:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. In addition, you have the right to request that we restrict our discloser of your PHI to only certain individuals involved in your care or the payment of your care.
3. **Inspection and copies:** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. Our practice may change a fee for the costs of copying, mailing and supplies associated with your request.
4. **Amendment:** You may request to amend your health information if you believe it is incorrect or incomplete. Your request must be made in writing and include a reason that supports your request for amendment.
5. **Right to a paper copy of this notice:** You are entitled to receive a paper copy of our notice of privacy practices.
6. **Right to file a complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services.

If you have any questions regarding this notice or our health information private policies, please contact **Karly Boswell**

Signature of patient/parent/guardian

Printed name of patient/parent/guardian and relationship to patient

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Release of Information

I understand that A Balanced Alternative, LLC has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow A Balanced Alternative, LLC to release some of my personal information to certain individuals or agencies.

I, _____, authorize A Balanced Alternative, LLC to share the following specific information with:

Name: _____

Specific Office/Agency:
_____

Phone Number: _____

The information may be shared: _____ in person _____ by phone

_____ by fax _____ by mail

_____ by email (I understand that electronic mail is not confidential and can be intercepted and read by other people).

Information to be shared:
_____

Why I want my information shared:
_____

This release expires on _____

I understand that I may withdraw my consent to this release at any time, in writing.

Signature: _____ Date: _____

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Medical Release Waiver

I certify that I am the parent or legal guardian for my child. I hereby give my permission for any Board Certified Behavior Analyst (BCBA) associated with A Balanced Alternative, LLC to seek and give appropriated medical attention for my child in the event of accident, injury, or illness, in the event I am not present. I will be responsible for any and all costs associated with any necessary medical attention and/or treatment.

I hereby waive, release and forever discharge A Balanced Alternative from all rights and claims for damages, injury, loss to person or property which may be sustained or occur during participation with A Balanced Alternative, LLC activities. I hereby acknowledge that my child is physically fit and capable of participation in any and all activities.

Signature _____
Date _____