• Central Texas Behavioral Solutions • (254) 554-1466 • www.ctbs.co •

CTBS CLIENT INFORMATION UPDATE PACKET

Financial Information

Central Texas Behavioral Solutions contracts with many major insurance payers and third-party funding sources. Please contact us to find out if we are currently a provider for your insurance company. We are always open to learning about your coverage or changes in practices and policies of insurers. You may also obtain information regarding insurance and funding sources on our website (www.ctbs.co)

It is our policy to invoice families for copays/cost-shares and private pay services on a weekly basis. You are eligible for the Prompt-Pay Discount only if you pay your invoice within one week of the date of receipt of invoice. If you are a Tricare/Humana Military Retiree or Reservist family, you will receive an invoice on a monthly basis. All invoices are sent to the primary email address on your patient information sheet.

CTBS utilizes a practice management system called Central Reach. You will be able to sign up for a Patient Portal where you may view your child's therapy schedule, invoices and service logs. You may also contact your child's provider via this HIPAA-protected, web-based portal. To register for Patient Portal please follow the directions included in this packet

We accept payment via check, cash or credit cards (Visa, MasterCard or Discover). In addition, we can accept payment via PayPal with special arrangements made through the Billing Manager.

Central Texas Behavioral Solutions has identified several grant sources that may, if approved, help offset therapy costs. Grant packets will be provided upon request.

For billing inquiries and payment arrangements you may contact:

Stacie Guice, Billing Manager
sguice@ctxbs.com
254-285-7499

Alan Tindell MBA, CFO
atindell@ctxbs.com
254-554-1466

I hereby agree to the financial policies stated above for Central Texas Behavioral Solutions.

Signature: _____ Date: _____

Printed Name: _____ Name of client: _____

Insurance Information

Primary Insurance Carrier:
Insurance Plan Name:
Name of Insured:
Sponsor ID or Member Number:
Group Number (If applicable):
Secondary Insurance Carrier (if applicable):

If Tricare/Humana, please check one: Active Duty ☐ Retiree ☐ Reservist ☐

If, at any time, there are changes to your insurance status it is your responsibility to let us know immediately. * THIS INCLUDES GOING FROM ACTIVE DUTY TO RETIREE/RESERVES. If there are gaps in insurance coverage due to changes, any fees incurred are patient responsibility.

If insurance is to be filed by CTBS:
I acknowledge via my initials and signature that:

Initial	
	I hereby authorize Central Texas Behavioral Solutions to furnish information to my insurance carrier(s) concerning my child's diagnosis and treatment.
	I hereby authorize payment of medical benefits to be paid directly to Central Texas Behavioral Solutions, ABA therapy provider
	I understand that even though insurance claims may be filed, I am still directly responsible for payment of this account if the claims are not paid by the insurance company.

Signature:	Date:

CHILD INTAKE QUESTIONNAIRE

CONFIDENTIAL

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of time. Please feel free to add any additional information which you think may be helpful in understanding your child. Central Texas Behavioral Solutions will hold information provided by you as strictly confidential and will only be released in accordance with HIPAA guidelines and as mandated by law. Please feel free to use the backs of pages for additional information.

Name of Person Completing this form: _____

Legal Name of the Child: _____

Nickname or name child routinely goes by: _____

Child's Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Home Address: _____
Street

_____
City State Zip

Home Telephone Number: ____ -_____ -_____ Work Phone(s): Mother: ____ - _____ - _____

Father: ____ - _____ - _____

Cellular Phone(s): Mother: ____- _____ - _____ Email(s): Mother: _____

Father: _____ - _____ - _____ Father: _____

Home Telephone Number ____- _____-_____ Work Phone(s): Guardian 1: _____-_____

Cellular Phone(s): Guardian 1_____-____-_____ Guardian 2 _____-_____-_____

Guardian 2 _____-____-_____ Email(s): Guardian 1 _____

Guardian 2_____

Preferred Method of Contact: Mother: ☐ Home ☐ Cell ☐ Email ☐ Work

Father: ☐ Home ☐ Cell ☐ Email ☐ Work

Guardian: ☐ Home ☐ Cell ☐ Email ☐ Work

SCHOOL INFORMATION (If Applicable):

School Name:_____ District:_____Grade:_____
School Telephone Number:_____ Contact Person:_____
Current Teacher (s): _____

Who referred you to our office?_____

Please describe the issues your child is now having, and what type of services you are seeking from us for these issues. Please use the back of this page for additional space if necessary.

PARENT INFORMATION

INDICATE PARENT/GUARDIANS LIVING IN THE HOME
Marital Status:
☐Married ☐Remarried ☐Divorced ☐Separated ☐Widowed ☐Single ☐Cohabitants
If divorced, please indicate who has physical/primary custody:_____Full or joint?_____
Who has legal custody?_____Full or joint?_____
If Military: Sponsor Rank_____Sponsor SSN_____

MOTHER'S/GUARDIAN'S INFORMATION

Mother's Name:_____
Date of Birth:_____Age:_____
Occupation:_____
Employer:_____
Education Completed:_____

FATHER'S/GUARDIAN'S INFORMATION

Father's Name: _____
Date of Birth:_____Age:_____
Occupation:_____
Employer:_____
Education Completed:_____

Does parent/guardian's job require them to be away from home for long hours or extended periods?
If parents are divorced and/or remarried, please list names of stepparents that may be bringing your child to therapy:

SIBLINGS

Name	Age	Relationship	Lives with client?	School	Grade

Please indicate any special needs or concerns regarding other children living in your home:

OTHERS: Please list any other individuals who currently live in the home with the client.

Name	Age	Relationship	Years Living in Home

List any serious operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had:

List any medications your child is currently taking or has taken for extended periods:

MEDICATION	PURPOSE	DOSAGE	DATES

Is your child on a special diet? ☐Yes ☐No
If yes, please explain:

Please check any of the following conditions that your child has had:

☐ Allergic reactions	☐ Earaches	☐ Hives	☐ Broken bones
☐ Ear infections	☐ Itchy eyes	☐ Constipation	☐ Eczema
☐ Seizures	☐ Dehydration	☐ Heart problems	☐ UTI
☐ Diabetes	☐ Hemorrhoids	☐ Asthma	☐

Which hand does your child write/hold pencil with? ☐Right ☐Left ☐No dominance shown yet

Name of child's physician (s): _____
Practice name: _____
Address: _____
Phone number: ___ - ___ - ____ Fax number: ___ - ___ - _____

When was your child diagnosed with ASD? _____ (age or year)

Is the initial (or most recent) diagnostic assessment report on file with CTBS? ☐Yes
☐No

If "No" please return a copy of the report with this packet

INFORMED CONSENT FOR SERVICES

APPLIED BEHAVIOR ANALYSIS (ABA THERAPY)

I understand that Central Texas Behavioral Solutions will use the science of ABA, its principles, concepts and other methodologies to allow my child to acquire adaptive and communicative behaviors. In addition, these methods will be used to reduce, eliminate and replace challenging behaviors. I understand that the individualized program will be designed to maximize my child's success. Methodologies and procedures used will include, but will not be limited to: Discrete trials, verbal behavior, natural environment training, prompts and reinforcement for appropriate responses. All procedures will be described and demonstrated at the request of the parent/guardian.

I understand that I will be notified of all interventions implemented for my child and that they are subject to my approval. Furthermore, I understand that I will be given a document outlining any procedures used and a written treatment plan.

PARENT PARTICIPATION EXPECTATIONS

I understand that for the maximum benefit for my child, my participation is essential. I understand that I am expected to (a) attend all meetings concerning my child, and (b) practice therapy procedures that are taught to me by the Central Texas Behavioral Solutions staff so that my child's skills will generalize from the therapy setting to a home and community environment more easily. Furthermore, I understand that if I do not attend meetings and generalize procedures at home, my child's progress may be limited. Measurable parent goals will be a critical part of my child's treatment plan.

I understand that the behavioral techniques that are used may not necessarily produce observable results during the course of time in which my child attends therapy with Central Texas Behavioral Solutions. The subsequent short and long term applications of these techniques have proven to be beneficial for other children with developmental disabilities and Central Texas Behavioral Solutions expects similar results for my child. I understand, however, that my child may or may not benefit. In addition, my child may experience behavior difficulties during and following time with Central Texas Behavioral Solutions. All efforts will be made to prevent, eliminate, and minimize such negative effects of participation.

Printed Name: _____ Name of Client: _____

Signature: _____ Date: _____

HIPAA SERVICE AGREEMENT AND STANDARD OPERATING PROCEDURES

This document contains important information about our professional services and business policies. It also contains summary information about the Health Information and Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with the information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligation imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us. You may also refer to our privacy and HIPAA notice on our website by clicking on the HIPAA emblem located on all pages. (ctbs.co)

For any HIPAA or privacy concerns you may contact our HIPAA privacy official:
Kim Overly 254-554-1466 or koverly@ctxbs.com

SERVICES OFFERED
We will provide services specifically designed to help you and/or your minor child, or otherwise provide you with referrals to other professionals. Our behavioral services consist primarily of individual behavioral and skill assessments, as well as short and long-term ABA service provision to youth/adults on the autism spectrum but are not limited to those areas.

ATTENDANCE
Except for rare emergencies, we will see your child at the time scheduled. We understand that circumstances (such as illness or family emergency) may arise which necessitate the occasional cancellation of appointments. Please refer to and sign our attached Attendance Policy.

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

TO PROTECT CLIENT FROM HARM
If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, an intended victim, a minor's parents, or others who could provide protection, or seek appropriate hospitalization. In addition, CTBS trains and certifies all staff on limiting the possibility of abuse annually through the Handle With Care system.

PROFESSIONAL CONSULTATIONS

Behavior Analysts routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them. Unless you object, we do not typically tell clients about these consultations, however these consultations will be so noted in your Private Health Information. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

RECORDS

We will review all testing results during our feedback session and offer you opportunities to ask questions and discuss the results with us. You will receive a written report that summarizes the findings. This report will include a summary and interpretation of all individual testing, as well as impressions from individual observations and consultations conducted as a part of a comprehensive individual evaluation. We will forward copies of any reports or written summaries to others only with specific, written consent from you, or as allowed under the law. Because of the proprietary nature of testing and program materials, we will release raw testing data only to other appropriately credentialed professionals (except as otherwise required by law).

PAYMENT FOR SERVICES

If necessary, we may seek assistance from an outside party in order to collect payment for services rendered to you. In such cases, any disclosures are limited to the minimum that is necessary to achieve the purpose. As you might suspect, the laws and professional standards governing these issues are quite complex, and it is important that we discuss any questions or concerns that you or your minor child may have at our first meeting, and as they may arise in the course of our work together. If any of these types of situations arise, we will make every effort to fully discuss it with you before taking any action, and we will limit disclosure to what is necessary. We are not attorneys, however, and you may wish to obtain formal legal consultation if you need specific advice.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in two sets of professional records. One set contains the Clinical Record and the other the professional's personal notes. The Clinical Record includes information about reasons for seeking our professional services; the impact of any current or ongoing problems or concerns, assessment, consultative, or therapeutic goals; progress toward those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Except in unusual circumstances that involve danger to yourself or others or makes reference to another person (unless such other person is a health care provider) and we believe that access is reasonably likely to cause substantial harm to such other person, you or your legal representative may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers or may contain information that is protected by federal copyright laws. For this reason, we recommend that you initially review them in the presence of one of our Clinical Directors or have them forwarded to another mental health professional so that you can discuss the contents.
In most cases we are allowed to charge a fee for copying (and for certain other expenses) plus postage and this is regulated under Texas law. The exceptions to this policy are contained in the attached Notice

Form. If we refuse your request for access to your records, you have a right of review (except for information provided to us confidentially by others) which we will discuss with you upon request. In addition, we also keep a set of Personal Notes for most clients to whom we provide even brief or consultative services. These notes are for the personal use of the professional alone and are designed to assist in providing you with the best treatment. While the contents of Personal Notes vary from client to client, they can include references to conversations, testing recording forms, data sheets, analysis from conversations, hypotheses of the professional, and the effects of these conversations on clients. They also may contain particularly sensitive information revealed that is not required to be included in the Clinical Record. Personal Notes are not available to you and cannot be sent to anyone else, including insurance companies. Your signature below waives all rights, now and in the future, to accessing these records in any form under circumstances. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

CONTACTING US

Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends). If you are difficult to reach, please leave sometimes when you will be available. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

I hereby acknowledge that I have read and agree to abide by the HIPAA regulations and Standard Operating Procedures of Central Texas Behavioral Solutions

Signature: _____ Date: _____

Printed Name: _____

Name of client: _____

HIPAA Authorization Form

I, _____ hereby authorize the use or disclosure of (client name) _____ protected health information as described below:

1. **AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTHINFORMATION**

_____ is authorized to disclose the following protected

health information to_____of_____

2. **DESCRIPTION OF INFORMATION TO BE DISCLOSED**

The health information that may be disclosed is: All past, present, and future periods of health care information.

3. **PURPOSE OF THE USE OR DISCLOSURE (use line below)**

_____

4. **VALIDITY OF AUTHORIZATION FORM**

This Authorization Form is valid beginning _____and expires on _____

5. **ACKNOWLEDGEMENT**

I understand that the information used or disclosed under this Authorization Form may be subject to redisclosure by the person(s) or facility receiving it and would no longer be protected by Federal Privacy Regulations.

I have the right to refuse this authorization form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Client/Child's Name:_____ DOB:_____

Parent/Guardian Signature: _____ Date: _____

CLIENT CONFIDENTIALITY CONTACT FORM

Client confidentiality is a top priority for Central Texas Behavioral Solutions. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.
In the event that I,_____, am unable to be reached, Central Texas Behavioral Solutions may leave information with the following:

☐ **Yes** ☐ **No** -Other adult in household (Name & #): _____

☐ **Yes** ☐ **No** -On home voice Mail (#): _____

☐ **Yes** ☐ **No** -On cell phone (#): _____

☐ **Yes** ☐ **No** -I may be reached at my work number (#): _____

☐ **Yes** ☐ **No** -May leave a message at work on my voice mail (#): _____

☐ **Yes** ☐ **No** -Other: (Please describe): _____

I understand that in the event that I am unable to be reached, if I have NOT given consent for alternate means of contacting myself or another responsible party in order, then I am taking the responsibility for retrieving information from Central Texas Behavioral Solutions upon myself, and any information that I have not received is of no fault of Central Texas Behavioral Solutions.
☐ **Yes** ☐ **No**

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of Central Texas Behavioral Solutions.
☐ **Yes** ☐ **No**

Client/Child's Name:_____ DOB:_____

Parent/Guardian Signature: _____ Date: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL AND MENTAL HEALTH RECORDS AND INFORMATION

SOURCE OF INFORMATION

Person or facility: _____

Address: _____

_____ Phone #: ___ - ___ - _____

CLIENT'S IDENTIFYING INFORMATION

Name: _____

Address: _____

_____

Phone #: ___ - ___ - _____ DOB: _____ Social Security #: ___ - ___ - _____

Parent/Guardian: _____

Address: _____

_____ Phone #: ___ - ___ - _____

I hereby authorize the source named above to send, as promptly as possible, the records marked below to Central Texas Behavioral Solutions at the address listed above. Please mark "yes" or "no" for each.

☐ **Yes** ☐ **No** -*Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness:* _____
Date(s) of inpatient admission: _____ Date(s) of discharge: _____
Start of outpatient treatment: _____ End of treatment: _____
Clinical/ Client #: _____
Other identifying information about the service(s) rendered:

☐ **Yes** ☐ **No** -*Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by and staff member or by the client.*

☐ **Yes** ☐ **No** -*Psychiatric evaluations, reports, or treatment notes*

☐ **Yes** ☐ **No** -*Treatment plans, recovery plans, aftercare plans*

☐ **Yes** ☐ **No** -*Admission and discharge summaries*

☐ **Yes** ☐ **No** -*Social histories, assessments with diagnosis, prognoses, recommendations, and all similar documents*

☐ **Yes** ☐ **No** -*Information about how the client's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.*

☐ **Yes** ☐ **No** -*Workshop reports and other vocational evaluations and reports.*

☐ **Yes** ☐ **No** -*Billing records*

☐ **Yes** ☐ **No** -*Academic or educational reports*

☐ **Yes** ☐ **No** -*Report of teachers/staff observations*

☐ **Yes** ☐ **No** -*Achievement and other test results*

☐ **Yes** ☐ **No** -*A letter containing dates of treatment(s) and a summary of progress*

☐ **Yes** ☐ **No** -*Other*: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL AND MENTAL HEALTH RECORDS AND INFORMATION

(continued)

I further authorize the source named above to speak by telephone with staff of Central Texas Behavioral Solutions (identified in the letterhead) about the reasons for my/the client's referral, and the relevant history or diagnosis, and other similar information that can assist with my/the client's receiving treatment or being evaluated or referred elsewhere.

I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe they are necessary to assist in the development of the best possible treatment plan. The information disclosed may be used in connection with my/the client's treatment.

In consideration of this consent, I hereby release the source of the records from any and all liability arising there from.

This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the client and arising out of an accident, injury, or occurrence to me/the client. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire 365 days from the date I sign it.

I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

_____	_____	_____
Signature	Printed Name	Date
_____	_____	_____
Signature of parent/guardian	Printed Name	Date

CTBS Policies, Rules and Regulations

ABSENCES, VACATIONS AND HOLIDAYS

- I/We understand that in the event of inclement weather, all programs at Central Texas Behavioral Solutions will follow along with the local public school's procedures. I/ We further understand that the Clinical Director has the discretion to cancel appointments due to exigent circumstances if needed even if the schools have not closed.
- I/ We understand that if the therapy location is closed, Central Texas Behavioral Solutions will also cancel or make arrangements to see your child elsewhere.
- Central Texas Behavioral Solutions has scheduled vacation breaks. I/We understand that we will be provided with a calendar of those scheduled breaks in advance.
- I/We understand that we must abide by the CTBS Attendance Policy (attached)

I ACKNOWLEDGE THAT: I have been provided, read and do understand Central Texas Behavioral Solutions' policy on absences, vacations, and holidays.

☐Yes ☐No

_____ Initial

ILLNESS POLICY

- I/We understand that if my child's temperature is at or above 100 degrees I/we will be contacted and that my/our child will be required to be picked up.
- I/We understand that my child must be fever free for a minimum of 24 hours before returning to therapy, without the aid of any fever reducing substance. I/We further understand that administering medicine such as Tylenol to reduce my child's fever so he/she can return to therapy are grounds for dismissal from the program.
- I/We understand the I/we will be called to pick up my child from therapy or home therapy if he/she has two (2) or more unexpected instances of diarrhea. I/We further understand that this does not apply to children that have chronic dietary issues that may cause excessive diarrhea when those issues have been previously discussed with the Clinical Director. I/We understand that my/our child will not be permitted to resume therapy until 24 hours have passed with no diarrhea instances.
- I/We understand that I/we will be called to pick up my child from therapy or home therapy if he/she has one (1) or more instances of vomiting. I/We further understand that this does not apply to self-induced vomiting. I/We understand that my/our child will not be allowed to resume therapy until 24 hours have passed with no instances of vomiting.
- I/We understand that I/we may bring my/our child to therapy if he/she has a common cold (slight occasional cough, clear runny nose, occasional sneezing). I/we further understand that if my/our child has discharge of any other color than clear, my/our child will not be seen for therapy. I/We also understand that if my/our child has a constant running nose which needs to be wiped continually, regardless of the color, he/she will not be seen for therapy. I/We understand that if my/our child has a runny nose which lasts for more than one (1) week in which I/we suspect is due to allergies, I/we will be required to bring a doctor's note stating this.
- I/We understand that if my/our child has any rash other than a mild diaper rash I/we must bring a note from the doctor stating the rash is not contagious.
- I/We understand that by law my/our child is not permitted to be seen for therapy if he/she has contracted a communicable disease. Examples of communicable diseases are (but not limited to): Conjunctivitis (Pink eye), Impetigo, Hepatitis A, Scabies, Ringworm, Infectious Diarrhea,

Chicken Pox, Scarlet Fever, Lice, and Strep Throat. I/we understand that if my/our child is thought to have a communicable disease I/we will be contacted and that my/our child will not be permitted to be seen for therapy. I/we further understand that my/our child will not be permitted to attend therapy until a doctor's note has been provided stating that my/our child is no longer contagious.

I ACKNOWLEDGE THAT: I have read and do understand Central Texas Behavioral Solutions' illness policy

☐**Yes** ☐**No**

_____ Initial

OBSERVATION OF CLIENT

- I/We understand that my/our child could be videotaped while receiving therapy from Central Texas Behavioral Solutions for the purpose of training staff members and/or receiving video updates on my/our child's progress. I/We understand that any video will be kept confidential.
- I/We understand that professionals, other clients, potential clients, staff, and therapists in training will occasionally be observing therapy. In these cases, I/we will be informed of the purpose of the observation.
- I/We understand that I/ We may view my/our child while he/she is receiving therapy. In addition, I/we may be asked to observe procedures in order to promote generalization.
- In the event of ANY observation in clinical areas, the observer must sign a HIPAA privacy agreement to be kept on file by CTBS.

I ACKNOWLEDGE THAT: I have read and do understand Central Texas Behavioral Solutions' policy on client observations.

☐**Yes** ☐**No**

_____ Initial

MEDICAL INFORMATION

- I/We understand that I/we have agreed to release my/our child's medical and psychological records to Central Texas Behavioral Solutions. Releasing these records will allow CTBS to review my/our child's diagnosis, developmental, medical, levels of intellectual, behavioral, and social functioning as well as their medical history. I/We understand that CTBS may require additional medical evaluations and/or testing.
- I/ We understand that I/we give CTBS permission to seek medical assistance for my/our child in case of an emergency. Medical attention will be sought without my/our verbal permission if I/we are either unreachable, time is of the essence, or other unforeseeable circumstances arise.
- I/we understand that there are medical conditions, as well as certain medications (such as insulin), that the staff of CTBS is not qualified to deal with and/or administer. If a medical condition arises that the staff is NOT able to handle, my child may not be able to be seen by the staff.

I ACKNOWLEDGE THAT: I have read and do understand Central Texas Behavioral Solutions' policy on obtaining medical information and/or assistance if the need arises.

☐**Yes** ☐**No**

_____ Initial

GIFTS/MONEY/PERSONAL FUNDRAISING

- I/We understand that the CTBS staff are not allowed to accept gifts, money or personal fundraising donations of any kind. This is per the Ethical Guidelines set forth by the Behavior Analyst Certification Board.

I ACKNOWLEDGE THAT: I have read and do understand Central Texas Behavioral Solutions' policy on gifts/money/personal fundraising

☐**Yes** ☐**No**

_____ Initial

NON-EVIDENCE BASED PRACTICES

- I/We understand that the CTBS does not promote or participate in any non-evidence based practices or treatments with or on behalf of clients. In some cases, non-evidence based practices may conflict with the recommendations in my child's ABA treatment plan. CTBS staff will discuss these conflicts with me/us at my request.
- I/We understand that the CTBS staff can consult with me/us at any time regarding selection of effective services to support and address my/our child's needs but that these will all be evidence-based recommendations.
- I/We understand that my/our child's ABA sessions are scheduled in accordance with clinical necessity and the staff of CTBS are not able to work around conflicts related to non-evidence based practices/appointments. If I/we have questions regarding this policy, we agree to communicate with the Clinical Director.

I ACKNOWLEDGE THAT: I have read and do understand Central Texas Behavioral Solutions' policy on non-evidence based practices

☐**Yes** ☐**No**

_____ Initial

ETHICS

- I/We understand that CTBS and its staff are governed by the Behavior Analyst Certification Board Code of Professional Practice and Ethics. In addition, CTBS maintains an ethics committee to review any ethical concerns.
- I/We understand that CTBS staff are aware of the potential for dual relationships and make every effort to avoid these. A dual relationship would include any relationship with the client or family outside the ABA/therapeutic relationship.
- I/We understand that if we are concerned at any time about the ethical practices of CTBS I may contact the Quality Assurance Officer: Kristin Tindell 254-554-1466

I ACKNOWLEDGE THAT: I have read and do understand Central Texas Behavioral Solutions' policy on ethics

☐**Yes** ☐**No**

_____ Initial

GENERAL INFORMATION

- I/We understand that if a snack or meal is necessary during my/our child's session, it is my/our responsibility to send that snack/meal for my/our child. I/we further understand that if my/our child is on a restricted diet that I/we will inform Central Texas Behavioral Solutions and they will do their best to make sure that my/our child does not ingest anything that is not an approved food on his/her diet.

- I/We understand that it is essential that we arrive with our child at the precise, scheduled therapy time. Furthermore, I/we understand that if circumstances arise that I/we am/are going to be late, I/we will be responsible for informing the therapist per the attendance policy.
- I/We understand that it is the policy of Central Texas Behavior Solutions not to discriminate against any client on the basis of race, color, religion, gender, physical condition or natural origin.

I ACKNOWLEDGE THAT I HAVE READ AND DO UNDERSTAND:

☐**Yes** ☐**No** -my/our responsibility to provide a snack/meal with necessary utensils for my/our child.

☐**Yes** ☐**No** -Central Texas Behavioral Solutions' policy on non-discrimination.

_____ Initial

HOME THERAPY PROTOCOL AND SAFETY AGREEMENT

Due to the nature of in-home therapy, there are some specific requirements to foster a safe environment that is conducive to skill-acquisition. Home is typically a place of leisure so interrupting typical activities in the home can be difficult and aversive. The following are guidelines for CTBS in-home ABA therapy.

- I/We understand that if a therapist is coming into my/our home to conduct therapy it is my responsibility to make sure that the environment is conducive to productive therapy.
- I/We understand that I/we must work with Central Texas Behavioral Solutions to set up the home environment for therapy and that this may involve designating a place within the home to conduct therapy that is free from distraction. This could be a table or a specific room where reinforcement can be controlled by the therapist.
- I/We understand that it is often more difficult to gain instructional control in the home setting and that escape behaviors are more likely to occur. I/we understand that we may have to work with the therapist to alleviate these behaviors and support the therapeutic environment.
- I/We understand that at least 30 minutes prior to the arrival of the therapist, all highly-reinforcing activities should be terminated so that my/our child does not associate the arrival of the therapist with the ending of reinforcing activities (television shows, video games, iPad, favorite games/toys etc.)
- I/We understand that it is important for the therapist to handle all behaviors in the home environment without interference in order to establish instructional control with the child. All procedures and techniques will be discussed with me/us in order to understand the reasoning behind the intervention.
- I/We understand that, for safety purposes, I must remain at home with the therapist and my child at all times.
- I/We understand that CTBS has the right to terminate in-home services with my/our child for any reason, at any time. If such termination occurs notice will be given immediately by the Clinical Director.

I ACKNOWLEDGE THAT:

I have read and do understand Central Texas Behavioral Solutions' policy on home therapy.

☐ **Yes** ☐ **No**

_____ Initial

-Signature Agreement for Rules and Regulations of Central Texas Behavioral Solutions-

_____ _____

Signature (Parent/ Guardian #1) Date

_____ _____

Signature (Parent/ Guardian #2) Date

Crisis and Intervention Prevention and Management

Central Texas Behavioral Solutions staff are trained in Handle With Care: Behavior Management System which has 3 levels of intervention: Support, Limit Setting and PRT (Physical Restraint Technique). The PRT is the ONLY physical technique in the history of the US Patent Office for "A Method for Safely Maintaining a Restraining Hold on a Person". Below are the conditions of the Central Texas Behavioral Solutions policy on using physical restraint.

A. Physical restraint is appropriate only when a client is displaying physical behavior that presents substantial imminent risk of injury to the client or others.

1. The client must demonstrate the intent and possess the ability to cause injury within a matter of minutes.
    - *Physical restraint should only be employed as a **last resort** after other methods of de-escalating a dangerous situation have been attempted without success.*
    - *Physical restraint should only be employed by staff members who have received Handle With Care training in the use of physical restraint procedures.*
    - *Other personnel may employ physical restraint procedures only in rare and clearly unavoidable emergency circumstances when fully trained personnel are not immediately available. Untrained staff should request assistance from trained staff as soon as possible.*

2. A physical restraint of a client should be conducted in a manner consistent with the techniques prescribed in the approved Handle With Care crisis intervention training program.
    - *Physical restraint should last only as long as is necessary for the client to regain behavioral stability, and the risk of injury has ended, usually a matter of minutes.*
    - *The degree of physical restriction employed must be in proportion to the circumstances of the incident, the size and condition of the client, and the potential risks for injury to the client.*
    - *Mechanical or chemical restraints are not authorized.*

B. Physical restraint is inappropriate when a client is NOT displaying physical behavior that presents substantial imminent risk of injury to the client or others.

1. *Physical restraint is not appropriate without imminent risk of injury to someone.*
2. *A verbal threat or verbally aggressive behavior does not itself indicate a substantial risk of injury and should not result in restraint.*
3. *Destruction or damage to property does not constitute a risk of imminent injury unless in so doing a risk of injury to the client or others is created.*
4. *When known medical or physical condition of the client would make the restraint procedures dangerous for that client (e.g., clients with heart or circulatory conditions, asthma, etc.) they should not be employed.*
5. *Restraint should never be used as a punishment, or to force compliance with demands.*

Central Texas Behavioral Solutions only employs the use of Handle With Care: Behavior Management System PRT (Physical Restraint Technique) for crisis management of emergency

situations where behavior that presents substantial imminent risk of injury to the client or others, not as a treatment for problem behavior. Due to the possibility of treatment of problem behavior evoking intense reactions from clients, it is necessary that Central Texas Behavioral Solutions be prepared and that you as the client/parent/guardian be informed of our policy. If you have any questions, feel free to ask, and if you would like to see the PRT so that you can feel comfortable giving consent, just ask and our staff will gladly walk you through the procedure and answer any questions.

I,_____, parent/guardian of

_____agree that I have been informed of CTBS Physical Restraint Policy and PRT procedures.

I,_____ , parent/guardian of

_____agree to allow staff of Central Texas Behavioral Solutions to employ the intervention mentioned in the policy above if the conditions for using physical restraint exist.

Parent/Guardian Signature_____

Date_____

Patient Complaint/Grievance Policy and Procedures

Central Texas Behavioral Solutions seeks to provide the highest quality services to our patients but we realize there may be times when issues arise that need to be resolved. Below are the internal and external grievance procedures for CTBS.

Policy Statement

Central Texas Behavioral Solutions (CTBS) is committed to providing quality patient care and promoting patient/family satisfaction.

CTBS staff shall handle all patient/family complaints and grievances consistently and in a timely manner.

CTBS shall track and trend complaints and grievances and implement necessary changes and process improvements under the direction of the Owner or his/her designee.

Definitions:

Complaint is defined as a verbal expression of dissatisfaction by the client/ family regarding care or services provided by CTBS which can be resolved at the point at which it occurs by the staff present. Most complaints will have simple solutions that can be promptly addressed and are considered resolved when the patient/family is satisfied with the action taken on their behalf.

Grievance is defined as a formal verbal or written expression of dissatisfaction with some aspect of care or service that has not been resolved to the patient/family's satisfaction at the point of service. All verbal or written complaints of abuse, neglect, patient harm or the risk of patient harm, a violation of the Patient Rights and Responsibilities are examples of grievances. A verbal or written complaint sent to the Owners or his/her designee or any request from a family to treat a complaint like a grievance will be considered grievance.

Procedures and Responsibilities

A. Complaints:

Responsible Party

1. 1. Any employee who receives a complaint from a patient/family member shall immediately attempt to resolve the complaint within that employee's role and authority.

2. If the complaint cannot be immediately resolved, the employee shall escalate the complaint through the appropriate chain of command.

3. The Clinical Supervisor or Clinical Director shall resolve the complaint or take steps to continue the resolution process with the knowledge and agreement of the patient/family making the complaint.

4. At any time during the complaint resolution process, The owner or his/her designee may be contacted for advice or support.

5. Upon completion or resolution of the complaint the employee of shall communicate all findings to the owner or his/her designee.

B. Grievances

1. If the complaint cannot be resolved or meets the definition of a grievance, the Clinical director responsible for the clinic where the grievance occurred shall complete a Patient Complaint/Grievance Form and notify the owner or his/her designee within 24 hours. The Owner will be notified immediately of any event that involves potential patient injury, any allegation of abuse or neglect or any potential for continued risk to patient safety or ethical violation.

2. The Clinical Director shall immediately notify the Privacy Officer of any complaint concerning privacy/patient confidentiality.

3. The owner shall assist the Clinical Director in the investigation of the grievance and shall determine if any peer review committee should be involved in any investigation. The investigation should address any identified opportunities for improvement.

4. Upon conclusion of the investigation, The owner shall assist the Clinical director in completing a final written summary of the investigation which shall be maintained on file by Owner.

5. The Owner shall provide a written response to the patient/family making the grievance. If the patient or authorized representative of the patient is not the person making the grievance, Protected Health Information of a patient that may be included in the investigation summary can only be released as allowed by law.

6. If the investigation of the grievance cannot be completed within 10 days, the Owner shall inform the person making the grievance that the investigation is continuing and that a written response will be forwarded immediately upon completion of the investigation. All grievances should be identified, reviewed and responded to within 30 days.

7. All complaints and grievances shall be logged, analyzed and tracked.

C. External Complaints/Grievances

If at any time you feel that CTBS is not adhering to the standards and ethics pertaining to excellent care and provision of ABA therapy you may report your complaint to external governing bodies to which CTBS is dedicated to adhering to. These are listed below:

Behavior Analytic Certification Board (BACB)

https://www.bacb.com/ethics-information//reporting-to-ethics-department/

Behavior Health Center of Excellence

https://bhcoe.org/become-a-bhcoe/report-a-compliance-concern/

I,_____, parent/guardian of

_____agree that I have been informed of CTBS

Complaint and Grievance Policies/Procedures

Parent/Guardian Signature_____

Date_____

CTBS Abuse Prevention and Mandatory Reporting Policy

Reporting Child Abuse or Neglect (as per the Texas Family Code 261.002)/ Video Training

We are required by state law to report any suspected child abuse, neglect or sexual molestation through the hotline at 1-800-252-5400 or online. Information to report suspected abuse/neglect is available from your Clinical Director or CEO.

You may also seek additional information at-
https://www.dfps.state.tx.us/ContactUs/report_abuse.asp

- ✓ A person having cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect by any person shall immediately make a report to the appropriate agency. They may do so without fear of discharge, retaliation or other disciplinary action.

- ✓ If the person is one of our staff members, their rights will be protected as well as the child/family involved.

- ✓ If a staff member has cause to believe that a child has been or may be abused or neglected, the professional shall make a report not later than the 48th hour after the hour the professional first

suspects that the child has been or may be abused or neglected. A staff member may not delegate or rely on another person to make the report. Staff will be immune from discharge, retaliation or other disciplinary action for that reason alone, unless it is proven the report was intended to do harm.

In the event a staff member is accused of child abuse or neglect whether professionally or personally, the following steps will be taken:

- Clinical Director and CEO notified.
- A call to CPS (1-800-252-5400) will be made, a report will be generated
- The Clinical Director will notify parents of the report.
- Once the alleged violation is reported, the employee will be suspended until the matter has been legally resolved.
- In the event there is not an identified offender, no therapist will be left alone with the client.
- The Clinical Director will provide access to administrative files, attendance records, work schedules; to investigators and other relevant personnel who have an official need to know.
- The Clinical Director will provide access to staff or parents for investigative interviews.
- The Clinical Director will be available to talk with parents, to keep a chronological log of events and keep the staff informed (to the extent that is appropriate/legal) of the case development through staff meetings.
- After 45 days of suspension, the position may/could be filled if the delay is due to lack of cooperation to authorities by the accused &/or if Licensing determines the person may not return until a decision is made by authorities.
- After 120 days, the employee may/could be terminated if the delay is due to lack of cooperation to authorities by the accused &/or if Licensing determines the person may not return until a decision is made by authorities.
- If the allegation is sustained, the employee will be terminated. If the employee is cleared, he/she may resume working with no change. No retaliation or 'harassment' of any type towards this person will be tolerated or permitted.
- There will be no appeal process of the termination.
- ***No staff member may discuss the incident unless it is on a need to know basis.*** **PERIOD.**

This organization has a ZERO tolerance policy regarding physical, sexual and emotional abuse of any child at any time, at any place.

Training

All staff members will receive detailed training on this policy as part of the New Employee Orientation process AND yearly through the extent of time employed with CTBS.

Adult Presence Policy

CTBS takes precautions to make sure that therapists and/or employees of any kind do not find themselves as the only adult present during sessions in clinic, community or in-home when working with clients. To avoid such circumstances CTBS does the following:

- All clinics will have more than one adult, to include at least one supervisor at all times when therapy is going on.
- All community outings will be attended by more than one adult/client pair.
- Parents will agree to and sign policy stating that therapists will not be left alone in the in home setting and that a parent will be present at all times.
- If a therapist or other employee finds himself/herself to be alone with a client, he or she will call supervisor immediately to report and alleviate the situation.

Steps for limiting the possibility of abuse:

CTBS therapists are training thoroughly every year in methods and procedures that limit the possibility of abuse. It is important that precautionary measures be taken to limit this possibility and the steps taken are as follows:

- All therapists are trained at time of hire in new employee orientation to prevent and limit possibility of abuse.
- Handle with Care Crisis Management/Verbal protocol teaches employees to recognize over-responding and under-responding when it comes to clients.
- The solid object protocol teachers employees to recognize signs when they are potentially triggered or dysregulated as a result of client or personal situation.
- Therapists are encouraged to request a break, support and/or assistance with clients when they find themselves in high-stress behaviors or situations that lead to dysregulation or high stress.
- Therapists/staff are given resources to deal with stressors (both personal and professional), such as counseling services, in order to be able to prevent undue stress with working with children.
- Supervisors are trained to recognize signs of dysregulation or undue therapist stress in order to provide support.

I,_____, parent/guardian of

_____agree that I have been informed of CTBS

Abuse Prevention and Mandatory Reporting Policy.

Parent/Guardian Signature_____

Date_____

CTBS Attendance Policy

Your child's success in behavioral therapy is a direct result of the regular attendance to your therapy program. We understand there will be times when your child will miss therapy appointments due to illness, vacation and unforeseen events. Communication with your child's therapist about absences allows us to maximize therapy time for your child and others. Below you will find our policies regarding absences. Please assist us in maximizing therapy time for your child and others.

REQUIRED ATTENDANCE POLICY

We expect clients to consistently attend scheduled therapy sessions. This includes changes in schedules due to school, vacation plans, and medical appointments.

- We require a minimum 85% attendance, per month, for standing therapy sessions. If attendance is not kept at 85% attendance rate per month, CTBS will reserve the right to decrease sessions or terminate services. (per our Interruption in Services Policy)
- You will receive written feedback at the end of each month regarding your attendance percentages, absences, tardies, no shows and/or late pick up times.

If your assigned therapist cancels a session, it will NOT be held against your attendance rate. We will attempt to find a sub or reschedule the session for another time if schedules allow.

CANCELLATIONS/NO SHOW POLICY/UNPLANNED ABSENSES

- In the case of illness (as defined in Illness Policy) please notify us (CTBS) as soon as possible. Clients may miss due to illness up to 5 times per year without consequence. Illnesses in excess of 5 per year will be reviewed by Executive Director for possible dismissal or reduction in service hours.
- No shows: Defined as no-call or cancelling in less than 24 hours (not due to illness). This will result in a no show $25.00 charge, payable at next encounter. Excessive no shows of more than 3 per year will result in reduction in service hours and possibly dismissal from program.
- Unexcused absence: Defined as any absence without proper notice. Any unexcused absence exceeding 5 days per year (total) may result in reduced sessions or possible termination of services.
- If your child is sick and you present a doctor's note for the absence, the absence will NOT count against your monthly percentage.

TARDY/LATE POLICY-ARRIVAL

- If you are going to be late, we ask that you notify your child's therapist immediately.
- If you are later than 15 min from the scheduled start time of your child's session, it will be counted as a tardy.
- 3 tardies will equal an absence.

- If you are later than 30 min from the scheduled start time of your child's session, your session will be cancelled and your child's therapist will be cleared to schedule with another client for the remainder of that session. This will be counted as an absence.

LATE PICK UP POLICY

- Your child must be picked up on time when their scheduled session ends and no later. Our therapists have other clients they need to transition to.
- We recommend that you arrive at least 10 minutes prior to the end of your child's session so that the therapist can transition your child to you and give you any relevant information regarding the session.
- If you are late for pick up, you will be assessed a late pick up fee of $1.00 per minute late. You will be invoiced for this and will be payable at next encounter.

INCLEMENT WEATHER POLICY

- In the event of inclement weather, all programs at Central Texas Behavioral Solutions will follow along with the local public school's procedures. The Clinical Director has the discretion to cancel appointments due to exigent circumstances if needed, even if the schools have not closed.
- If the therapy location is closed, Central Texas Behavioral Solutions will also cancel or make arrangements to see your child elsewhere.

VACATION/PLANNED ABSENCE POLICY

- Central Texas Behavioral Solutions has scheduled vacation breaks. We will provide parents with an annual calendar of vacation periods and we encourage parents to take vacation during these closures.
- Vacations from program of 4 business days or less require at least 72-hour notice to enable therapists to fill that time with other clients. Failure to notify within 72 hours will result in an unexcused absence occurrence.
- Vacations greater than 4 business days require 30-day's notice. Failure to notify within 30 days will result in an unexcused absence occurrence

ILLNESS POLICY

- Children out due to illness will not be considered an unexcused absence occurrence.
- I/We understand that if my child's temperature is at or above 100 degrees I/we will be contacted and that my/our child will be required to be picked up.
- I/We understand that my child must be fever free for a minimum of 24 hours before returning to therapy, without the aid of any fever reducing substance. I/We further understand that administering medicine such as Tylenol to reduce my child's fever so he/she can return to therapy is grounds for dismissal from the program.
- I/We understand that I/we will be called to pick up my child from therapy or home therapy sessions ended, if he/she has two (2) or more unexpected instances of diarrhea. I/We further understand that this does not apply to children that have chronic dietary issues or other medical conditions, that may cause excessive diarrhea when those issues have been previously discussed with the Clinical Director. A doctor's note may be required for these instances. I/We understand that my/our child will not be permitted to resume therapy until 24 hours have passed with no diarrhea instances.

- I/We understand that I/we will be called to pick up my child from therapy or home therapy sessions ended, if he/she has one (1) or more instances of vomiting. I/We further understand that this does not apply to self-induced vomiting. I/We understand that my/our child will not be allowed to resume therapy until 24 hours have passed with no instances of vomiting.
- I/We understand that I/we may bring my/our child to therapy if he/she has a common cold (slight occasional cough, clear runny nose, occasional sneezing). I/we further understand that if my/our child has discharge of any other color than clear, my/our child will not be seen for therapy
- I/We understand that if my/our child has any rash other than a mild diaper rash I/we must bring a note from the doctor stating the rash is not contagious.
- I/We understand that by law my/our child will not permitted to be seen for therapy if he/she has contracted a communicable disease. Examples of communicable diseases are (but not limited to): Conjunctivitis (Pink eye), Impetigo, Hepatitis A, Scabies, Ringworm, Infectious Diarrhea, Chicken Pox, Scarlet Fever, Lice, and Strep Throat. I/we understand that if my/our child is thought to have a communicable disease I/we will be contacted and that my/our child will not be permitted to be seen for therapy. I/we further understand that my/our child will not be permitted to attend therapy until a doctor's note has been provided stating that my/our child is no longer contagious.

I ACKNOWLEDGE THAT: I have read and do understand Central Texas Behavioral Solutions' attendance policy

☐ **Yes** ☐ **No**

Parent/Guardian
Name:_____

Signature:_____

Child/Client Name: _____

Date:_____

CTBS Client/Family Rights and Responsibilities Agreement

Central Texas Behavioral Solutions is committed to providing quality care to our clients and to help each of them achieve maximum potential in all facets of life (home, community, school). In addition, we pledge to provide these services with care, respect and dignity.

Although these rights are written for the child/client, they also apply to the client's parent or legal guardian, as you are an extension of the client relationship with CTBS.

At CTBS we expect staff, clients, families and visitors to act in a reasonable, respectful and responsible way at all times.

If you have a concern about the rights or responsibilities, you are encouraged to discuss the concern with the staff involved, the Clinical Supervisor for your child's program, or your Clinical Director on site. If you are still concerned, you may also arrange to speak with the Owner/Executive Director by coordinating this with the Clinical Director.

AS A CLIENT OF CTBS…..YOUR RIGHTS

- You have the right to considerate, respectful care at all times and under all circumstances, with recognition of personal dignity.
- You have the right, within the law, to personal and informational privacy.
- You have the right to expect reasonable safety insofar as the company's practices and clinic environments are concerned.
- You have the right to timely verbal and written communication.
- You have the right to refuse treatment to the extent permitted by law. When the refusal of treatment by a client, or their legally authorized representative, prevents the provision of appropriate care in accordance with professional standards, the client/CTBS relationship may be terminated upon reasonable notice.
- You have the right to expect that CTBS clinical staff is competent to obtain and interpret information in terms of your child's needs and to have an understanding of the range of treatment needed.
- The family and/or legal guardian of the child have the right to be involved in the child's continuing care.
- You have the right to assistance for conflicts regarding services rendered. If applicable, the assigned staff/clinical supervisor should always be made aware of any conflict. If resolutions of conflict cannot be achieved with the client/family through the staff involved, the client/family has the right to request a meeting with the Clinical Director who has the authority to resolve conflicts and/or to involve the Owner/Executive Director in the ultimate resolution.

AS A CLIENT OF CTBS……YOUR RESPONSIBILITIES

- Provide, to the best of your knowledge, accurate and complete information about present issues, past illnesses, hospitalizations, medications and other matters relating to your child's health.
- Participate in regularly scheduled parent training and meetings required to remain updated on treatment protocols and progress as required by CTBS and all insurance providers.
- Follow treatment plans recommended by the CTBS Clinical Supervisors.
- Be responsible for your actions if you refuse treatment or do not follow the recommended treatment protocols.
- Assure that the financial obligations of your child's health care/services are fulfilled as promptly as possible.
- Be responsible for keeping your insurance information/coverage/policy numbers up to date with CTBS Billing Department.
- Be considerate of the rights of other clients of CTBS in terms of confidentiality and privacy.
- Communicate considerately and respectfully to all staff of CTBS and follow communication hierarchy to address concerns.
- Be respectful of the specific clinical guidelines for drop off, pick up and adherence to attendance policies agreed upon at the onset of services.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Printed Name Client Name Printed

Central Texas Behavioral Solutions A Behavioral Health Center of Excellence