



**Client Information Form**

**JAIR-V ABA Services LLC**

3347 Corporate Parkway  
Center Valley, PA 18034  
Phone: (610) 709-4035

**Client Information**

**Client Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**Medical Information Medical**

**Conditions:**

**Current Medications:**

**Treatment History**

**Previous Treatment(s):**

**Drug and Alcohol Concerns (if applicable):**

**Insurance & Financial Information**

**Insurance Provider:** \_\_\_\_\_

**Policy/Member ID #:** \_\_\_\_\_

**Group #:** \_\_\_\_\_

**Contact Information**

**Address:** \_\_\_\_\_

**County of Residence:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Employment / School Information**

**Employer / School Name:** \_\_\_\_\_

**Employer / School Address:** \_\_\_\_\_

**Emergency Contact**

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

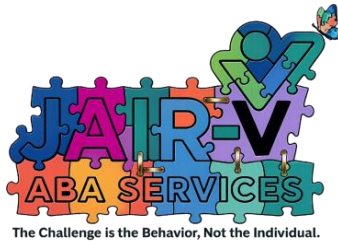
**Phone Number:** \_\_\_\_\_

**Acknowledgment**

I certify that the information provided above is accurate and complete to the best of my knowledge.

**Client/Guardian Name (Printed):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## **Applied Behavior Analysis (ABA) Intake Addendum**

Please complete the following questions to assist us in understanding your child's needs and determining appropriate services.

### **1. Reason for Interest in ABA Services**

Please describe your primary concerns and the behavioral or developmental challenges you would like addressed through ABA services:

### **2. Diagnostic History**

Please provide information regarding any previous diagnoses, evaluations, or assessments (e.g., autism spectrum disorder, developmental delays, psychological evaluations), including dates and providers if known:

### **3. Developmental History**

Please describe relevant developmental history, including milestones (e.g., speech, motor skills), early concerns, and any previous interventions or therapies:

### **Additional Information (Optional)**

Please include any other information you feel would be helpful in understanding your child's needs:

## **Developmental & Behavioral History (ABA Addendum)**

Please complete the following sections to help us better understand your child's developmental and behavioral needs.

### **4. Developmental Milestones**

*(Please indicate the approximate age when each milestone was achieved, if known)*

- Sitting independently: \_\_\_\_\_
- Walking independently: \_\_\_\_\_
- Eating solid foods: \_\_\_\_\_
- Sleeping independently in own bed: \_\_\_\_\_
- Toilet trained: \_\_\_\_\_
- Speaking single words: \_\_\_\_\_
- Speaking in phrases (two or more words): \_\_\_\_\_

### **5. Current Concerns / Behavioral or Skill Deficits**

Please describe current concerns, including behavioral challenges or areas where additional support is needed (e.g., communication, social skills, daily living skills, maladaptive behaviors):

### **6. Previous Interventions**

Please describe any strategies, interventions, or supports that have been used in the past to address these concerns, including therapy, school supports, or home-based strategies:

### **7. Perceived Causes or Triggers**

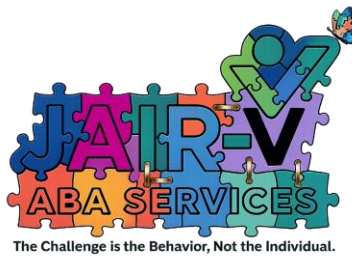
Please describe any patterns, triggers, or situations that you believe may contribute to the behaviors or concerns described above:

**8.** Past ABA or mental health intervention history:

**9.** What motivates your child to engage in adaptive ("good") behavior:

**10.** Does your child have a script for ABA services:     Yes or No (please circle)

**11.** What types of services are you seeking (school-based, home or community)



## Client Rights and Responsibilities

### JAIR-V ABA Services LLC

3347 Corporate Parkway

Center Valley, PA 18034

Phone: (610) 709-4035 | Fax: (888) 453-0085

## Client Rights

Clients receiving services have the right to:

- Be treated with dignity and respect at all times
- Receive services without discrimination based on race, color, religion, gender, ethnicity, age, disability, national origin, or source of payment
- Have their personal and treatment information kept confidential, except as permitted or required by law
- Access services in a timely and appropriate manner
- Be informed of available treatment options, regardless of cost or insurance coverage
- Participate actively in the development of their individualized treatment plan
- Receive information in a language they understand, at no cost when feasible
- Obtain a clear explanation of their diagnosis, condition, and recommended treatment options
- Receive information about the agency, its providers, programs, and role in their care
- Be informed of the clinical guidelines used to manage and deliver services
- Request information about provider qualifications, including training and experience
- Provide input regarding policies related to client rights and responsibilities
- Be informed of advocacy services, community resources, and prevention programs
- Request advocacy support from the agency when appropriate
- File a grievance or appeal without fear of retaliation and be informed of the process
- Be informed of their rights and responsibilities throughout treatment
- Request preferences regarding their provider whenever possible
- Have treatment decisions made based on clinical need and medical necessity
- Receive information about contracted service providers, when applicable
- Decline participation in services or withdraw from treatment at any time
- Be informed of the staff responsible for their care and how to request changes in services

## Client Responsibilities

Clients receiving services are responsible for:

- Treating staff and providers with dignity and respect
- Providing accurate and complete information necessary for care and service delivery
- Asking questions to better understand their treatment and services
- Participating in and following the agreed-upon treatment plan
- Following prescribed medication plans, if applicable
- Informing providers of any changes in medications or treatment from other sources
- Attending scheduled appointments and providing timely notice of cancellations
- Communicating when the treatment plan is not meeting their needs
- Notifying providers of concerns related to financial obligations or fees
- Reporting suspected abuse, neglect, or fraud
- Expressing concerns regarding the quality of care received
- Informing the agency and provider if they choose to withdraw from services

## Acknowledgment

My signature below indicates that I have been informed of my rights and responsibilities and understand the information provided.

**Client/Guardian Name (Printed):** \_\_\_\_\_

**Client/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The signature below indicates that this information has been explained to the client and that a copy has been offered.

**Provider Name (Printed):** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



3347 Corporate Pkwy  
Center Valley, PA 18034  
Phone: 610-709-4035  
Fax: (888) 453-0085

### **Consent for Use and Disclosure of Protected Health Information (PHI)**

This form serves as an agreement between you, the undersigned individual (or legally authorized representative), and Valerie K. Arrindell.

As part of providing behavioral health services—including evaluation, diagnosis, treatment, and referral—we will collect information about you that is protected under federal and state law, known as Protected Health Information (PHI). This information is necessary to determine appropriate services, develop treatment plans, and provide quality care.

Your PHI may be used and disclosed for the following purposes:

- To provide treatment and coordinate care with other healthcare providers or agencies
- To obtain payment for services rendered
- For healthcare operations, including administrative, quality assurance, and compliance activities
- For purposes required or permitted under applicable federal regulations and Pennsylvania OMHSAS requirements

By signing this form, you authorize the use and disclosure of your PHI as described above. Additional details regarding how your information may be used and disclosed, as well as your rights, are outlined in the **Notice of Privacy Practices**. You are encouraged to review this document prior to signing.

Please note that if you choose not to sign this consent form, we may be unable to provide services to you, as the use of your health information is necessary for treatment and operational purposes.

We may update our privacy practices from time to time. If changes are made, you may request an updated copy of the Notice of Privacy Practices at any time by contacting our privacy officer or calling 610-709-4035.

You have the right to request restrictions on how your PHI is used or disclosed for treatment, payment, or healthcare operations. Such requests must be made in writing. While we will make every effort to honor your

request, we are not required to agree to all requested restrictions. If we do agree, we will comply with the agreed-upon limitations, except where disclosure is required by law.

You also have the right to revoke this consent at any time by submitting a written request. Revocation will apply to future uses and disclosures; however, it will not affect any actions already taken in reliance on this consent prior to its revocation.

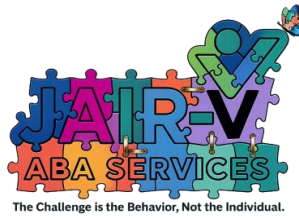
**Signature of Individual/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA <span style="float: right;">PICA <input type="checkbox"/></span>														
1. MEDICARE <input type="checkbox"/> (Medicare) MEDICAID <input type="checkbox"/> (Medicaid) TRICARE <input type="checkbox"/> (TRICARE) CHAMPVA <input type="checkbox"/> (Member/Covered) GROUP HEALTH PLAN <input type="checkbox"/> (GHP) PECA EXCLUSION <input type="checkbox"/> (PECA) OTHER <input type="checkbox"/> (Other)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>X</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>X</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>X</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>X</b>		5. PATIENT'S SEX M <input type="checkbox"/> F <input type="checkbox"/>					
6. PATIENT'S ADDRESS (No. Street) <b>X</b>					7. PATIENT RELATIONSHIP TO INSURED <b>X</b> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) <b>X</b>							
CITY <b>X</b>			STATE <b>X</b>		8. RESERVED FOR NUCC USE			CITY <b>X</b>		STATE <b>X</b>				
ZIP CODE <b>X</b>			TELEPHONE (Include Area Code) ( )		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR PECA NUMBER <b>X</b>			
3. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					12. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR PECA NUMBER <b>X</b>				
4. OTHER INSURED'S POLICY OR GROUP NUMBER					13. CLAIM CODES (Designated by NUCC)					12. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
5. RESERVED FOR NUCC USE					14. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below. SIGNED <b>X</b> DATE					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED <b>X</b>				
6. RESERVED FOR NUCC USE					15. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.					14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
7. INSURANCE PLAN NAME OR PROGRAM NAME					16. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPJ _____					15. OTHER DATE MM DD YY QUAL.				
8. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 10, and 11.					18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
9. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer A-L to service line below (IAC) ICD 9th.					17. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES				
10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					20. OCCURRENCE CODE ORIGINAL REF. NO.					18. PRIOR AUTHORIZATION NUMBER				
11. DATE OF SERVICE From MM DD YY To MM DD YY					21. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS I WOODPECKER					19. CHARGES				
12. PLACE OF SERVICE EMS					22. DIAGNOSIS PORTER					20. DISCHARGE DATE (MM DD YY)				
13. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.)					23. SERVICE FACILITY LOCATION INFORMATION					21. RECEIVING PROVIDER ID #				
14. FEDERAL TAX I.D. NUMBER SSN EIN					24. PATIENT'S ACCOUNT NO.					22. ACCEPT ASSIGNMENT? (For 90% Deductible Plans) YES <input type="checkbox"/> NO <input type="checkbox"/>				
15. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.)					25. TOTAL CHARGE \$					23. AMOUNT PAID \$				
16. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.)					26. BILLING PROVIDER INFO & PH # ( )					24. FEDERAL TAX I.D. NUMBER SSN EIN				



**Guardian Attestation**

**JAIR-V ABA Services LLC**

3347 Corporate Parkway Center  
Valley, PA 18034

Phone: (610) 709-4035

Fax: (888) 453-0085

I, \_\_\_\_\_, attest that I am the legal guardian of the individual receiving services.

Please indicate your status:

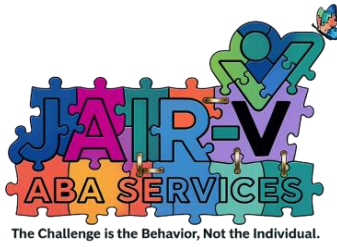
Yes, I have legal guardianship

No, I do not have legal guardianship

**Client Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## Client Communication & Contact Authorization

We may need to contact you regarding your care or administrative matters. Examples include:

- Appointment reminders or cancellations (including due to weather or unforeseen circumstances)
- Follow-up after assessments, evaluations, or therapy sessions
- Verification of personal or insurance information
- Requests for additional information
- Communication with authorized external parties (e.g., probation officers, attorneys), when applicable

To maintain compliance with HIPAA regulations, we require your written permission to contact you and to indicate whether we may leave messages.

## Contact Information

Please complete the following:

Contact Method	Information	Permission to Leave Message
Home Phone	_____	Yes / No
Cell Phone	_____	Yes / No
Work Phone	_____	Yes / No
Email Address	_____	Yes / No
Text Messaging ( <i>scheduling purposes only</i> )	_____	Yes / No

## Emergency Contact

**Emergency Contact Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Important Notice**

- Phone calls, emails, and text messages may not be fully secure
- Text messaging should only be used for scheduling purposes
- Clinical or sensitive information should not be shared via text or unsecured email
- Communications may become part of your clinical record

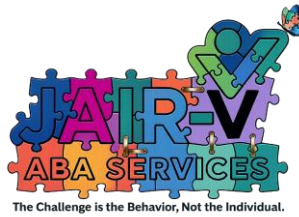
**Authorization and Consent**

By signing below, you authorize JAIR-V ABA Services LLC to contact you using the methods listed above and in accordance with your indicated preferences.

**Client Name (Printed):** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian (if applicable):** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## **Non-Discrimination Policy**

### **JAIR-V ABA Services LLC**

3347 Corporate Parkway  
Center Valley, PA 18034  
Phone: (610) 709-4035  
Fax: (888) 453-0085

## **To Our Clients and Community Members**

JAIR-V ABA Services LLC is committed to providing services in a manner that promotes dignity, respect, and equal access for all individuals.

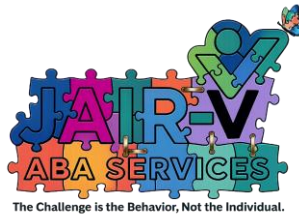
## **Non-Discrimination Statement**

Admissions, referrals, and the provision of services are conducted without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, sex, or any other protected classification under applicable federal or Pennsylvania law.

## **Accessibility of Services**

Services will be made accessible to eligible individuals with disabilities through reasonable and appropriate accommodations. These may include, but are not limited to:

- Providing auxiliary aids or communication supports (e.g., written communication for individuals who are hearing impaired)
- Offering services in alternative settings based on client need (e.g., home or community-based services for individuals with sensory sensitivities or environmental challenges)
- Adjusting service delivery methods to best meet the needs of the individual and family



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### **Language Access and Interpretation Services**

We strive to provide equitable access to services for individuals with Limited English Proficiency (LEP):

- Clients may utilize a qualified interpreter of their choosing during services
- Referrals will be provided to language-specific providers when appropriate
- If interpretation or translation needs cannot be met internally, the client will be referred to appropriate services that can meet their linguistic needs

### **Filing a Discrimination Complaint**

Any individual who believes they have been subjected to discrimination may file a complaint with:

#### **Privacy/Compliance Officer (or Designee)**

JAIR-V ABA Services LLC  
Phone: (610) 709-4035

### **External Agencies**

#### **Pennsylvania Department of Human Services**

Bureau of Equal Opportunity  
Health and Welfare Building, Room 225  
P.O. Box 2675  
Harrisburg, PA 17105

#### **Pennsylvania Human Relations Commission**

Harrisburg Regional Office  
333 Market Street, 8th Floor  
Harrisburg, PA 17101



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### **Commitment to Equity**

JAIR-V ABA Services LLC is dedicated to maintaining an inclusive, respectful, and accessible environment for all individuals and continuously improving services to meet the diverse needs of the community.

Sincerely,

Valerie K. Arrindell Owner and Ceo



## Grievance and Appeal Policy

### JAIR-V ABA Services LLC

3347 Corporate Parkway  
Center Valley, PA 18034  
Phone: (610) 709-4035  
Fax: (888) 453-0085

### Purpose

This policy ensures that individuals receiving services have the right to express concerns or complaints regarding their care, treatment, or services. It establishes a structured, fair, and timely process for resolving grievances and appeals in accordance with applicable Pennsylvania regulations and internal quality standards.

### Statement of Principles

- All individuals have the right to be treated with dignity and respect
- Individuals have the right to participate in treatment decisions
- Individuals may express concerns or file complaints without fear of retaliation
- When informal resolution is not successful, individuals have the right to pursue formal grievance and appeal procedures
- Information about this process will be provided at intake and upon request

### Policy Statement

JAIR-V ABA Services LLC is committed to:

- Protecting client rights throughout the grievance and appeal process
- Ensuring timely, fair, and objective resolution of concerns
- Maintaining documentation of grievances for quality improvement and regulatory compliance
- Supporting access to external review through appropriate local, state, and federal agencies

### Definitions

- **Grievance:** A formal complaint regarding services, treatment, or rights
- **Appeal:** A request for review of a grievance decision
- **Client:** The individual receiving services or their authorized representative

## Notification of Rights

Clients will be informed of their rights, including the right to file a grievance, at intake and annually thereafter. Written acknowledgment will be obtained. If a client is unable to sign, documentation will be completed by staff and witnessed.

## Internal Grievance Procedure

### 1. Filing a Grievance

- Grievances may be submitted orally or in writing at any time • Assistance will be provided upon request
- Grievances may be submitted to:

#### **Administrative Director / Designee**

Phone: (610) 709-4035

### 2. Investigation and Response

- An impartial review will be conducted by a designated individual not involved in the issue
- A written decision will be issued as soon as possible, **within 48 hours when feasible**
- If additional time is required, the client will be notified and provided with an updated timeline
- All findings and actions will be documented in the client record

### 3. Oversight and Documentation

- The Privacy Officer or designee will oversee grievance reviews when appropriate
- All grievances will be tracked and logged
- Final resolution will be documented within a reasonable timeframe, not to exceed **90 days**

## Appeal Process

### First-Level Appeal

- Must be submitted in writing within **10 business days** of the initial decision
- Reviewed by a designated review committee or impartial examiner
- The client may have an advocate or legal representative present
- A written determination will be issued within **10 business days**

### Second-Level Appeal

- Must be submitted within **10 business days** of the first-level appeal decision
- May be reviewed by appropriate external authorities, including the **Pennsylvania Department of Human Services (DHS)**
- A final determination will be issued following review

## External Grievance Options

Clients may also file complaints directly with the following:

### Managed Care Organizations (Example)

#### Magellan Behavioral Health of Pennsylvania

- Phone (Lehigh/Northampton): 1-866-238-2311
- Fax: 1-888-656-2380

#### Community Care Behavioral Health (CCBH)

- Online grievance portal available

### Pennsylvania Department of Human Services (DHS)

Office of General Counsel  
Health and Welfare Building  
Harrisburg, PA 17120

### Pennsylvania Department of Health

100 Lackawanna Avenue, Suite 200  
Scranton, PA 18503

### Federal Civil Rights Complaints

Office for Civil Rights  
U.S. Department of Health and Human Services  
Philadelphia, PA  
Phone: 1-800-368-1019

### Grievance Tracking and Quality Improvement

- All grievances will be documented and monitored
- A written summary of resolution will be maintained in the client record
- Trends will be analyzed to improve service quality and prevent recurrence

### Acknowledgment and Consent

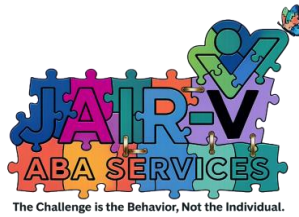
I acknowledge that I have received and understand the Grievance and Appeal Policy and my rights related to filing a grievance.

**Client/Guardian Name (Printed):** \_\_\_\_\_

**Client/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Individual Signature (if applicable):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## HIPAA Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### Overview

This Notice of Privacy Practices explains how we may use and disclose your Protected Health Information (PHI) to provide treatment, obtain payment, and conduct healthcare operations, as well as for other purposes permitted or required by law.

It also describes your rights regarding your health information.

**Protected Health Information (PHI)** includes any information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health condition and related healthcare services.

We are required by law to maintain the privacy of your PHI and to provide you with this notice outlining our legal duties and privacy practices.

### Our Responsibilities

- We are required to follow the terms of this Notice currently in effect
- We reserve the right to change the terms of this Notice at any time
- Any revised Notice will apply to all PHI we maintain
- You may request a copy of the most current Notice at any time by contacting our office

### How We Use and Disclose Your Information

We may use and disclose your PHI without your prior authorization for the following purposes:

#### 1. Treatment

We may use your PHI to provide, coordinate, or manage your healthcare and related services.

**Examples include:**

- Sharing information with other providers involved in your care
- Referring you to specialists or other treatment services

**2. Payment**

We may use and disclose your PHI to obtain payment for services provided.

**Examples include:**

- Billing insurance companies
- Verifying eligibility or obtaining prior authorization
- Submitting claims or documentation for reimbursement

**3. Healthcare Operations**

We may use or disclose your PHI to support our business activities and improve quality of care.

**Examples include:**

- Quality assessment and improvement activities
- Staff training and supervision
- Licensing and accreditation processes
- Administrative and operational functions

**Other Permitted Uses and Disclosures**

We may also use or disclose your PHI as permitted or required by law, including:

- Public health and safety reporting
- Compliance with legal proceedings
- Reporting abuse or neglect
- Law enforcement purposes, when required

**Your Rights**

You have the following rights regarding your PHI:

- **Right to Access:** You may request copies of your health records
- **Right to Amend:** You may request corrections to your information
- **Right to Request Restrictions:** You may request limits on how your information is used or disclosed
- **Right to Confidential Communications:** You may request how and where we contact you
- **Right to Revoke Consent:** You may withdraw your consent in writing at any time (to the extent permitted by law)

## **Requests and Questions**

To exercise your rights, request a copy of this Notice, or ask questions about your privacy rights, please contact:

### **Privacy Officer**

Phone: 610-709-4035

## **Changes to This Notice**

We reserve the right to revise this Notice at any time. Updated versions will be available upon request and will apply to all protected health information we maintain.

## **Acknowledgment**

By receiving services, you acknowledge that you have been provided with this Notice of Privacy Practices.



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### **Informed Consent Acknowledgment**

By signing below, I acknowledge that I have received, read, and understand the Informed Consent Statement. This document outlines important information regarding the nature of services, including:

- Counseling and treatment processes
- Appointments, fees, and billing practices
- Insurance and payment responsibilities
- Communication and contact procedures
- Confidentiality and its limits
- Professional boundaries and dual relationships
- Social media and electronic communication policies

I understand that I have the opportunity to ask questions and discuss any concerns with my provider. I further understand that policies may be updated periodically, and I will be notified in writing of any changes and provided with an updated copy.

**Consent for Services**

Please indicate the service(s) for which you are providing consent:

- Individual Counseling Services
- Individual/Family Counseling Services
- Applied Behavior Analysis (IBHS/ABA) Services
- Mental Health Evaluation

**Acknowledgment and Signatures**

I voluntarily consent to participate in the service(s) selected above.

**Individual Name (Printed):** \_\_\_\_\_

**Individual Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Signature (required if individual is under 14 years of age):**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Name (Printed):** \_\_\_\_\_

**Witness Name (Printed):** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Medicaid-eligible members will not be charged fees for covered services in accordance with applicable federal and Pennsylvania regulations.



3347 Corporate Pkwy  
Center Valley, PA 18034  
Phone: (610) 709-4035  
Fax: (888) 453-0085

## **Permitted Uses and Disclosures of Protected Health Information (PHI)**

We may use or disclose your Protected Health Information (PHI) without your written authorization when permitted or required by applicable federal and Pennsylvania law, including the following circumstances:

### **Law Enforcement**

We may disclose your PHI for law enforcement purposes when required by law or in response to a valid legal process.

### **Coroners, Medical Examiners, and Funeral Directors**

We may disclose PHI for identification purposes, determining cause of death, and to assist authorized individuals in carrying out their legal duties. PHI may also be disclosed for organ, eye, or tissue donation purposes.

### **Research**

We may disclose PHI for research purposes when the study has been approved by an Institutional Review Board (IRB) and appropriate safeguards are in place to protect your privacy.

### **Serious Threat to Health or Safety**

We may use or disclose PHI when necessary to prevent or reduce a serious and imminent threat to your health or safety or that of others, in accordance with applicable laws.

### **Military and National Security**

If applicable, we may disclose PHI of individuals involved in military activities or national security as required by authorized officials.

### **Workers' Compensation**

We may disclose PHI as necessary to comply with workers' compensation laws and similar programs that provide benefits for work-related injuries or illness.

### **Correctional Institutions**

If you are an inmate or under the custody of law enforcement, we may disclose PHI as necessary for your care or for the safety and security of the facility.

## **Fundraising**

We may contact you regarding fundraising activities. You have the right to opt out of receiving such communications at any time.

## **Required by Law**

We will disclose PHI when required by federal or state law, including compliance investigations conducted by the U.S. Department of Health and Human Services or other regulatory authorities.

## **Uses and Disclosures Requiring Your Written Authorization**

Certain uses and disclosures of your PHI require your explicit written authorization, including:

- Most uses and disclosures of psychotherapy notes
- Use of PHI for marketing purposes
- Disclosures that constitute the sale of PHI
- Any other use not otherwise described in this Notice

You may revoke your authorization at any time in writing, except to the extent that action has already been taken based on your prior authorization.



## **Uses and Disclosures of Protected Health Information (PHI)**

### **Individuals Involved in Your Care**

Unless you object, we may disclose your PHI to a family member, relative, close friend, or other person you identify who is involved in your care or payment for your care.

If you are unable to agree or object, we may use professional judgment to determine whether disclosure is in your best interest. We may also use your PHI to notify or assist in notifying a family member or responsible party of your location, general condition, or, in the event of death, to assist with necessary arrangements.

Additionally, your PHI may be shared with authorized public or private entities for disaster relief purposes to coordinate care and notification.

### **Emergency Situations**

We may use or disclose your PHI during emergency treatment situations. If possible, we will attempt to obtain your consent as soon as reasonably practicable after the emergency has passed. If consent cannot be obtained, we may still use or disclose your information as permitted by law to ensure appropriate care.

### **Other Permitted or Required Uses and Disclosures Without Authorization**

We may use or disclose your PHI without your written consent, authorization, or opportunity to object in the following circumstances, as permitted or required by federal and Pennsylvania law:

#### **Required by Law**

We may disclose PHI when required to do so by federal, state, or local law. Any such disclosure will be limited to the relevant requirements.

#### **Public Health Activities**

We may disclose your PHI to public health authorities authorized by law to collect information for preventing or controlling disease, injury, or disability.

#### **Communicable Diseases**

We may disclose PHI, when authorized by law, to a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading the disease.

#### **Health Oversight Activities**

We may disclose your PHI to health oversight agencies for activities such as audits, investigations, inspections, and licensure reviews. These agencies oversee the healthcare system, government programs, and regulatory compliance.

**Abuse or Neglect**

We may disclose your PHI to appropriate authorities if we suspect abuse, neglect, or domestic violence, consistent with applicable laws and reporting requirements.

**Food and Drug Administration (FDA)**

We may disclose your PHI to the FDA or other authorized entities for activities related to product safety, adverse event reporting, recalls, repairs, or post-marketing surveillance.

**Legal Proceedings**

We may disclose your PHI in the course of judicial or administrative proceedings, such as in response to a court order, subpoena, or other lawful process, as permitted by law.



## Telehealth Consent to Treat

**Client Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Provider/Agency Name:**

Jair-V ABA Services LLC

### 1. Description of Telehealth Services

Telehealth services involve the use of secure, HIPAA-compliant technology to deliver behavioral health services remotely. Services may include:

- Assessment
- Diagnosis
- Treatment
- Consultation
- Supervision

Telehealth sessions may be conducted using the following HIPAA-compliant platforms:

- Zoom
- Microsoft Teams

### 2. Location of Services

- **Provider Location:** Office or approved clinical setting
- **Client Location:** The client's chosen location at the time of service

The client agrees to inform the provider of their **physical location at the beginning of each session** for safety and emergency purposes.

### 3. Equipment and Technology Requirements

Telehealth services require access to:

- A computer, tablet, or smartphone
- Reliable internet or data connection
- Audio and video capability

## 4. Roles and Responsibilities

### Provider Responsibilities:

- Deliver clinical services
- Maintain confidentiality in accordance with HIPAA
- Document services appropriately

### Client Responsibilities:

- Actively participate in services
- Maintain privacy in their environment
- Inform the provider of any concerns or changes

## 5. Voluntary Participation and Right to Refuse

Participation in telehealth services is voluntary. The client has the right to:

- Refuse telehealth services at any time
- Request in-person services (when available)
- Withdraw consent without penalty

Refusal of telehealth services will **not** impact access to other available services.

## 6. Alternatives to Telehealth

Alternatives may include:

- In-person services (when available)
- Referral to another provider or appropriate services

## 7. Emergency Procedures

Telehealth services are **not appropriate for emergencies**.

If an emergency occurs or the connection is lost, the client should:

- Call **911**, or
- Contact a local crisis resource below:

**County Crisis Intervention (24/7):**

- Northampton County: 610-252-9060
- Lehigh County: 610-782-3127
- Carbon, Monroe & Pike Counties: 570-992-0879 or 800-849-1868

**National Resource:**

- 988 Suicide & Crisis Lifeline (Call or Text 988)

**8. Consent for Minors and Adolescents**

- For clients **under age 14**, consent must be provided by a parent or legal guardian
- For clients **age 14 and older**, consent may be provided by the client in accordance with state laws
- Parent/guardian involvement will occur when required or clinically appropriate

**9. Duration of Consent**

This consent is valid for the **duration of the current episode of care.**

- Consent is typically obtained once per episode of care
- All consent activities will be documented in the clinical record

**10. Acknowledgment and Consent**

I have read (or had explained to me) the information above regarding telehealth services. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.

I voluntarily consent to participate in telehealth services under the terms described in this document.

Signatures

**Client Signature (Age 14+):** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent/Guardian Name (if applicable):** \_\_\_\_\_

**Relationship to Client:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**Suicide Risk Screening Form (ASQ)**

**National Institute of Mental Health (NIMH)**

**Client Information**

**Client Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Date of Screening:** \_\_\_\_\_

**Staff Completing Screening:** \_\_\_\_\_

**Important Resources (Provide to All Clients)**

- **988 Suicide & Crisis Lifeline:** Call or Text 988 (24/7) En Español: 1-888-628-9454
- **National Suicide Prevention Lifeline:** 1-800-273-8255
- **Crisis Text Line:** Text “HOME” to 741-741

**Screening Questions**

**Ask the client the following questions:**

1. In the past few weeks, have you wished you were dead?  
 Yes  No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  
 Yes  No
3. In the past week, have you been having thoughts about killing yourself?  
 Yes  No
4. Have you ever tried to kill yourself?  
 Yes  No

If **YES**, describe:

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**When did this occur?**

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### Acuity Question (Ask ONLY if “Yes” to any above)

1. Are you having thoughts of killing yourself right now?  
 Yes  No

If YES, describe:

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### Scoring & Clinical Next Steps

- If the patient answers “NO” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (\*Note: Clinical judgment can always override a negative screen).
- If the patient answers “YES” to any of the questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity.

#### Negative Screen

- If all answers to Questions 1–4 are **NO**:
  - Screening is complete
  - No further action required
  - Clinical judgment may still apply

#### Positive Screen (Non-Acute)

- “YES” to question #5= **Acute positive screen** (imminent risk identified)
  - Patient requires a **STAT** safety/full mental health evaluation
  - **The patient cannot leave until evaluated for safety**
  - Keep the patient in sight. Remove all dangerous objects from the room. Alert physician or clinician responsible for patients care

#### Positive Screen (Acute)

- If “NO” to Question 5= Non-acute positive screen (potential risk identified)
  - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. **The patient cannot leave until evaluated for safety.**
  - Require **immediate (STAT) safety evaluation**
  - **Do not leave the client unattended**
  - Alert physician or clinician responsible for patients care

### Clinical Notes

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**Staff Signature**

**Name (Printed):** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## **Your Rights Regarding Protected Health Information (PHI)**

You have the following rights with respect to your Protected Health Information. Below is a summary of these rights and how you may exercise them:

### **Right to Access and Obtain Copies**

You have the right to inspect and obtain a copy of your PHI contained in a designated record set for as long as we maintain the information.

A designated record set may include medical and billing records and other records used to make decisions about your care.

Please note that certain records may be restricted from access under federal or state law.

### **Right to Request Restrictions**

You have the right to request restrictions on how your PHI is used or disclosed for treatment, payment, or healthcare operations. You may also request that information not be shared with certain individuals involved in your care.

Requests must be made in writing, and you must specify:

- The information you want restricted
- Whether the restriction applies to use, disclosure, or both
- To whom the restriction applies

While we will consider your request, we are not required to agree to all requested restrictions. If we do agree, we will comply except in emergency situations.

### **Right to Confidential Communications**

You have the right to request that we communicate with you regarding your health information by alternative means or at alternative locations. We will accommodate reasonable requests.

### **Right to Request Amendment**

You have the right to request that your PHI be amended if you believe it is incorrect or incomplete.

If we deny your request, you have the right to submit a written statement of disagreement, and we may prepare a rebuttal, which will be included with your record.

### **Right to an Accounting of Disclosures**

You have the right to request an accounting of certain disclosures of your PHI that we have made, excluding those related to treatment, payment, and healthcare operations.

This request must specify a time period and may be subject to certain limitations under applicable law.

### **Right to a Copy of This Notice**

You have the right to receive a paper copy of this Notice of Privacy Practices at any time, even if you have agreed to receive it electronically.

### **Right to Notification of a Breach**

You have the right to be notified if a breach occurs involving your unsecured PHI, in accordance with federal and state law.

### **How to Exercise Your Rights**

To exercise any of these rights or to ask questions, please contact our Privacy Officer at the phone number provided.