

Emergency Information

Child's Name: _____ Parent/Guardian: _____

Street: _____ Work Phone: _____

City/State/Zip: _____ Parent/Guardian: _____

Home Phone: _____ Work Phone: _____

Part 1

Please list an emergency contact other than parent/guardian:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Preferred Hospital: _____

Preferred Doctor: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Part 2

Authorization to seek emergency health care in the event a parent or guardian cannot be reached.

In the event that reasonable attempts made to contact me at the numbers listed above have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above doctors. In the event the above doctors are not available, another licensed doctor may provide treatment. I also authorize for my child to be transported to the above named hospital or any hospital this accessible.

This authorization does not cover major surgery unless the doctor deems it as a life threatening decision.

Parent/Guardian Signature: _____ Date ___/___/___

Part 3

Do not complete Part 2 if you chose to complete Part 3.

I do not give consent for emergency medical treatment of my child. In the event I cannot be contacted in an emergency situation, I wish that no action be taken or (actions you wish to be taken):

Parent/Guardian Signature: _____ Date ___/___/___

Abilities First Autism Learning Center

SIGNATURE PAGE

Client: _____

I, _____, have read and agree to the following:
(Print Parent/Guardian Name)

Agree

Disagree

_____	_____	Outings within a Neighborhood Block
_____	_____	Consent to Photograph/Video for AF public relations/AF Social Media
_____	_____	Consent to Video for educational purposes of myself, AF staff or other allied professionals

The following information was explained and/or given to me:

_____ Family Rights and Responsibilities Code of Ethics

_____ Attendance Policy

_____ Notice of Privacy Practices (HIPAA)

_____/_____/_____
Signature Date

_____/_____/_____
AF Employee Signature Date

Abilities First Pediatric Therapies/Autism Learning Center

Consent Form

Please check agree or disagree in each section and then sign bottom of form.

Consent for Treatment:

_____Agree _____Disagree

I give permission for my child, _____,
To receive evaluation/screening/treatment by PT/OT/SLP at Abilities First

Consent for Observation:

_____Agree _____Disagree

I give permission to the Pediatric Therapies program to permit students in the health professions, technicians and other such persons as the staff may deem fit to observe or be supervised in treating my child during an evaluation/ screening and/or treatment session. It is understood that any information revealed during such observations and/or supervisions will be held in strict confidence.

Consent to Photograph/Video for Abilities First public relations including social media:

_____Agree _____Disagree

Parent/Guardian

Date

**Acknowledgement of Receipt of HIPAA Notice of Privacy Practices
ABILITIES FIRST**

**ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of Abilities First's **HIPAA Notice of Privacy Practices**.

Patient/Student Name (Please Print)

Patient/Student Signature

Date

OR

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

Parent Guardian Power of Attorney Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use Only

I tried to obtain written acknowledgement from the individual noted *above* of receipt of our **Notice of Privacy Practices**, but could not because:

____ An emergency prevented us from obtaining acknowledgement.

____ A communication barrier prevented us from obtaining acknowledgement.

____ The individual was unwilling to sign.

____ Other: _____

Staff Member Signature

Date

Abilities First Pediatric Therapies/Autism Learning Center
GENERAL INFORMATION

Date: _____

Child's Name: _____

Male _____ Last _____ First _____ Middle _____
Female _____

Child's Social Security# _____ Birthdate: _____

Referring Physician: _____

Diagnosis: _____

Parent/Guardian – Mother: _____ Birthdate _____

Parent/Guardian – Father: _____ Birthdate _____

Address: _____

City: _____ State: _____ Zip code: _____ County _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Cell Phone: _____

E-mail address: _____

If different from Parent/Guardian:

Birth Mother's Name: _____ Birthdate: _____

Birth Father's Name: _____ Birthdate: _____

Race:

___ White/Caucasian ___ Black/African American ___ Asian ___ Multi-Racial
___ Native Hawaii/Pacific Islander ___ American Indian/Alaskan Native ___ Other

Ethnicity: ___ Hispanic ___ Non-Hispanic

Household Income:

___ \$0-\$9,999 ___ \$10,000-\$14,999 ___ \$15,000-\$24,999
___ \$25,000-\$34,999 ___ \$35,000 & Above ___ Unknown



Autism Learning Center Attendance Policy

It is our goal to assist your child in making as much progress as possible. For that to happen, consistent attendance is essential.

Where does drop off and pick up occur?

Drop off and pick up occurs outside of your student's classroom.

***Drop-off** occurs no earlier than 5 minutes prior to the start of your child's class time:

- Preschool: 9:00am
- School-Age: 8:45am

*If you arrive after 9:30am for Preschool, 9:15am for School-Age, wait in the lobby and a staff member will walk your child to their assigned classroom**.*

***This is to limit disruption, as activities have already begun.*

*****At 10:00am, your child has been marked absent and you need to call first before arriving tardy.**

***Pick-up** occurs no earlier than 5 minutes prior, to 10 minutes after, the end of your child's class time:

- Preschool: 2:00pm – 2:10pm
- Kindergarten – 2nd Grade: 3:00pm – 3:10pm

**LATE PICKUP CHARGE: Your child(ren) must be picked up 10 minutes after their class time in order to avoid a late pickup charge.

- If you find that you will be late in arriving to the center, please call for planning purposes.
- The charge will be \$50.00 per 20 minutes per child after 2:10pm for Preschool, and after 3:10pm for K-2.
- **If no contact has been made with a parent or designee by: 3:00pm for Preschool, 4:00pm for K-2, the local children's services authority will be called.**
- Habitual late pick-ups could jeopardize your child's spot in the program.

What is my responsibility in notifying ALC staff when my student cannot attend?

You are responsible for calling the Abilities First Front Office at 513-423-9496, emailing Sarah.Watts@abilitiesfirst.org or Jen.Marshall@abilitiesfirst.org, or messaging ALC staff on Brightwheel **within one hour of the start of the school day.**

What is considered an excused or unexcused absence?

We understand people cancel or miss school for a variety of reasons. The following are the definitions of excused and unexcused absences:

Excused Absence: An illness, accident or other emergency situation, or a notification within one hour to the start of the school day. The absence will be considered unexcused until a parent/guardian makes direct contact with the Director or Assistant Director to verify the student's absence, or provide written documentation (e.g., doctor's note).

Unexcused Absence: Not notifying the ALC staff, not showing up for school, or a non-emergency situation in which a call is received less than 4 hours in advance of the school day.

What happens after twelve (12) for Preschool, fourteen (14), for School-Age, excused absences?

If your Preschool student has twelve (12), or your School-Ager has fourteen (14), excused absences within the quarter, they will lose their spot in the Autism Learning Center program and be placed on the waiting list, to be called as availability arises.



What if my child is sick for two (2) weeks in a row (i.e. – chicken pox) or we are on vacation?

This will be considered as one (1) excused absence since it all stems from the same issue.

What happens after six (6) unexcused absences?

If your child has six (6) unexcused absences within the quarter, your child will lose their spot in the Autism Learning Center program and be placed on the waiting list, to be called as availability arises.

Will I be notified if my student is about to be withdrawn from the program?

Yes, the Director of Autism Learning Center will notify you by phone, email, and in person (if able).

Student Name: _____

Parent/Guardian Signature _____

Date _____

AF Employee witnessed _____

Date _____



Autism Learning Center CLIENT/FAMILY RIGHTS

- The client/family has the right to considerate and respectful care.
- The client/family has the right to know the name and qualifications of anyone providing his/her care.
- The client/family has the right to expect that all communications and records pertaining to his/her care will be treated confidentially.
- The client/family has the right to receive information to make informed consent.
- The client/family has the right to express feeling and opinions and to be listened to, and taken seriously.
- Except in situations of child endangerment, the client/family has the ultimate decision regarding which type of services to use or refuse. Services may not be given without client/family consent.
- The client/family has the right to give input into the IEP and to obtain ongoing information about progress toward goals.
- The client/family is entitled to have full access to information regarding their child. Families may or may not choose to have information shared between agencies.
- The client/family have the right to investigate and pursue solutions for any issues regarding for any issue regarding the client's therapy with the therapists and/or all levels of management within the agency.
- Abilities First does not engage in discrimination of clients or staff based on place of residence, race, creed, color, nation origin, disability, sex, religion, or source of payment.

Autism Learning Center CLIENT/FAMILY RESPONSIBILITIES

Your responsibilities as a client/family include:

- Providing accurate health care information.
- Participating in goal setting with IEP team members.
- Following the prescribed course of care and treatment, including home programming.
- Adhering to the attendance policy, including providing or arranging for transportation and being on time for school.
- Providing the Director of ALC or the Children's Programs Service's Coordinator with all changes regarding the child's general information (i.e. name, address, funding, guardianship, phone number changes, etc.)

6/2022

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires abilities first to maintain the privacy of clients receiving services and enrolled in our programs. We are required to provide clients with notice of our legal duties and privacy practices with respect to their personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of the Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. If revisions are made to this Notice, you will be given a copy and asked to acknowledge receipt.

Use and Disclosure Of Your Health Information

Use for Treatment: We will use or disclose your health information for treatment purposes, including for the treatment activities of other health care providers. Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. That way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

Use for Payment We will make use or disclose your personal health information as necessary for payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, we may forward information regarding your medical treatment to your insurance company to arrange for payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Health care operations: We will use and disclose your health information as necessary, and as permitted by law, for other health care operations, which include clinical improvement, professional peer review, business management, accreditation and licensing etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and care of our patients. We may also disclose your personal health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

NOTICE OF PRIVACY PRACTICES

Family and Friends Involved In Your Care: With your approval, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individual's without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside person or organizations, such as auditing, accreditation, legal services, etc. At times, it may be necessary for us to disclose parts of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Fundraising: We may contact you as part of our fundraising efforts. You have the right to "opt-out" of receiving fundraising material/communications and may do so by orally notifying our organization.

Food and Drug Administration (FDA): We may disclose to the FDA, or to a person or entity subject to the jurisdiction of the FDA, health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose your personal health information to the extent that it is authorized and necessary to comply with the laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your personal health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institutions: Your personal health information may be disclosed for your health and the health and safety of others, should you become incarcerated or permanently detained in a corrections facility.

NOTICE OF PRIVACY PRACTICES

Reports: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more individuals, workers or the public.

Rights That You Have

Access to Your Personal Health Information: You have the right to obtain a copy and /or inspect much of the personal health information that we retain on your behalf. You have a right to obtain an electronic copy of your health information that exists in an electronic format and you may direct that the copy be transmitted directly to the entity or person designated by you provided that any such delegation is clear, conspicuous, and specific with complete name and mailing address or other identifying information. All requests for access must be made in writing and signed by you.

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care. This includes medical billing records. To inspect and copy this Health Information, you must make your request in writing. We have 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. For more information about this right, see 45 CFR 164.524.

Right to Amend: If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Requests to amend records must be in writing, and must provide a reason to support the amendment. For more information about this right, see 45 CFR 164.526.

Right to Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. (not to exceed 6 years) You will not be charged for any request for accounting of disclosures made in the first twelve months of care/service. However, you will be charged for any request made after the first twelve months. For more information about this right, see 45 CFR 164.528.

Restrictions on Use and Disclosure of your Personal Health Information: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend.

NOTICE OF PRIVACY PRACTICES

To request a restriction, you must make your request, in writing to the Privacy Officer. We are not required to agree to your restriction request, except when the restriction request pertains to a disclosure to a health plan for purpose of carrying out payment or health care operations when the information pertains solely to a health care service for which we have been paid in full. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. You also have the right to terminate, in writing, any agreed-to restriction by submitting a request to our Privacy Officer. For more information about this right, see 45 Code of Regulations (CFR 164.522(a)).

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way. Examples, text only. All requests for confidential communication must be in writing.

Breach Notification: In the unlikely event that there is a breach, or unauthorized release of your personal health information, you will receive notice and information on steps you may take to protect yourself from harm.

Complaints: If you believe your privacy rights have been violated, you may file a complaint to us in writing. You may also file a complaint with Secretary of the U.S. Department of Health and Human Services at Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601, in writing within 180 days of a violation of your human rights. There will be no retaliation for filing a complaint.

Acknowledgement of Receipt of Notice: You will be asked to sign an acknowledgment form that you received this Notice of Privacy Practices.

For Further Information and Requests: If you have questions or need further assistance regarding this Notice, or wish to exercise any of the rights stated in this Notice, you may contact the Privacy Officer at (513) 423-9496

Effective Date: The Notice of Privacy Practices is effective 10/22/2019

ABILITIES FIRST CODE OF ETHICS

- Abilities First provides a commitment to interdisciplinary treatment and supports the contributions of a variety of disciplines to the field of habilitation.
- The conduct of individuals providing services at Abilities First will be consistent with all applicable local, state, and federal regulations and codes of conduct established by individual disciplines. These individuals are committed to increasing their knowledge of pediatric and adult therapies, residential services, child care, education, and employment services. Every effort will be made to safeguard the health and welfare of clients who seek service.
- Marketing, advertising, communications, and solicitation practices will reflect a true representation of what is being offered to clients, the community, and donors.
- Abilities First's Corporate Compliance Officer will facilitate an annual review/revision of the Code of Ethics to be approved by the President and Board. He/she will ensure new and existing employees are aware of the code. He/she will have open access to all financial records and external auditors, the authority to expand the scope of the audit if deemed necessary to safeguard the corporate assets, and serve as a resource to employees and other persons regarding concerns about the behavior of any employee or related party with regards to ethical and perceived inappropriate behavior.
- Members of the Board of Trustees are also responsible for the confidentiality and business practices of Abilities First. The Board is responsible for all issues addressed in policies and by-laws including human resources. All Board members are required to read and sign a Conflict of Interest Statement and the Board Code of Ethics annually.
- Code of Ethics violations by employees will be handled according to Policy 006-2 (Corrective Action) and reported to the Leadership Team. Students/interns/volunteers and contractual staff who violate the Code of Ethics will be released from their contracts.
- The following ethical directives are based upon the organization's set of core values identified as communication, collaboration, integrity, customer focus, empowerment, innovation, and fiscal responsibility.
 - Employees/others as identified above will maintain their skills and competency and conduct themselves in a professional manner to provide the greatest benefit for the client.
 - Employees/others as identified above will provide only those services for which they are qualified to perform and treat all individuals fairly.
 - Employees/others as identified above obligated to safeguard information obtained in the course of their involvement with a client. Individuals seeking services will be advised of the HIPAA regulations.
 - Employees, contracted individuals and students practicing at Abilities First will accurately represent and disclose their education, training, and experience.
 - Abilities First will adhere to all federal, state, and local laws regulating business practice. Abilities First will not enter into any arrangement where fees are exchanged that would create a conflict of interest or influence opinions about services rendered. Employees/others as identified above engaging in research will identify as a priority the safety of their subjects. Investigation will be consistent with the traditions and practices of the individual's discipline. Research activities will not be conducted without prior review of the President and the Human Rights Committee.