SUPER KIDS
Comprenhensive ABA Therapy

ADMISSION FORM

Client's Name: _____DOB: _____ Date: _____

The following people are authorized to pick up my child from Super Kids Development Center, I authorize the release of my child to their care.

Name	Relation	Phone Number

Additional Comments:

Caregiver Initials _____ Caregiver Initials _____

17121 NE 6TH AVE, North Miami Beach, FL 33162
Phone : (786) 955-6224 / (305) 952-3161 Fax : (786) 364-7244
E-mail : admin@superkidsaba.com / info@crystalkidscenter.com
Superkidsaba.com

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1. HIPAA CONSENT AND DISCLOSURE

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. We understand that his or her medical information is personal to you, and we are committed to protecting that information. As our client, we create medical records about your child's health, our care for him/her, and the services we provide for your child. By law, we are required to make sure that your child's protected health information is kept private.

By signing this form, you consent to our use and disclosure of protected health information about your child for treatment, payment, and health care operations. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I_____, have received a copy of the HIPAA privacy practices and understand its terms or have been provided to have its terms explained to me.

Caregiver Initials _____ Caregiver Initials _____

2.PERMISSION TO PHOTOGRAPH

Super Kids Development Center (SKDC) likes to use pictures of students/clients in our website, brochures, invitations, slideshows, etc. This form allows or prohibits SKDC to use your child's picture or videotape for marketing purposes.

☐ Yes, I give permission for my child to be photographed for publicity or fundraising purposes to benefit SKDC. My child's first name may be used; however, if my child is to be identified by first and last name, I must be notified in advance to give express approval prior to publication.

☐ No, please do not use pictures of my child for anything outside of the center.

Caregiver Initials _____ Caregiver Initials _____

3.PERMISSION TO VIDEOTAPE

Super Kids Development Center (SKDC) likes to use videos of students/clients on our website, brochures, invitations, slideshows, etc. This form allows or prohibits SKDC to use your child's picture or videotape for marketing purposes.

☐Yes, I give permission for my child to be videotaped for publicity or fundraising purposes to benefit SKDC. My child's first name may be used; however, if my child is to be identified by first and last name, I must be notified in advance to give express approval prior to publication.

☐No, please do not use videos of my child for anything outside of the center.

Caregiver Initials _____ Caregiver Initials _____

4. DIGITAL MEADIA RELEASE FORM

At Super kids Development Center (SKDC), we are always seeking to enhance our staff's knowledge and training. In doing so, we would like to ask your permission to record your child during sessions for the purpose of educating and training our staff. In addition, some supplies / stimuli such as visual supports are best implemented with actual photos of our clients.

If you do not want your child recorded FOR ANY REASON, there is NO obligation to agree to your child being recorded. SKDC will never record your child without your permission.

I _____, agree to the recording; video, audio and / or still imagery / photograph of my child, for the purpose of creating materials for my child's program including but not limited to training, supervision within the company documenting baseline information and visual support systems. I understand that the footage will be used to help train and educate SKDC staff on intervention procedures.

I _____, agree to the recording; video, audio and / or still imagery / photograph of my child, for the purpose of educating researchers, educators, and families at various conferences, trainings, workshops, or other educating venues. I will allow my child's footage to be used for the purpose of research and training of individuals outside of SKDC.

I _____, **do not agree** to the recording; video, audio and/or still imagery/ photograph of my child, for any reason and will not consent to the recording or photographing of my child by SKDC staff.

Caregiver Initials _____ Caregiver Initials _____

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5. CONSENT FOR TREATMENT

Client Name: _____ DOB: _____.

I _____, agree to have my child evaluated/treated through Super Kids Development Center (SKDC). I understand that these services are based on an Applied Behavioral Analysis (ABA) model and will be provided by a professional trained in ABA. I understand that state laws may require that confidentiality be broken under certain circumstances, specifically, if I am judged by the behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected child abuse.

I understand that treatment will increase the problem behavior at first (Extinction period) and then the behavior will improve significantly and be replaced for another appropriate behavior. I acknowledge that no guarantee has been made to me as the result of evaluation and/or treatment. I also understand that treatment will involve physical participation on the part of the client which may involve the risk of injury. Parents are responsible for making the therapist aware of any changes in your child's physical or mental status.

I also understand that SKDC specializes in the evaluation and treatment of problem behaviors as well as skill acquisition, and if SKDC is unable to meet my particular needs, I will be referred to an appropriate agency or individual.

Services: SKDC implements Applied Behavior Analysis for its services. A variety of techniques are integrated and utilized during treatment. You will be encouraged to practice various skills introduced in sessions. A treatment plan with specific goals will be explored and updated according to treatment plan schedules. Recommendations for additional treatment and/or intensive treatment may be made if needed. Parent involvement in the program is required. Family involvement is an important part of treatment. Children under the age of 18 will require a parent's signature (or legal guardian) to receive any form of treatment.

In my absence, I consent that my child/client may receive therapy under the care of Super Kids Therapist.

The child may be left at SKDC facility with his/her assigned therapist ONLY when receiving therapy services. Parents/caregivers MUST be in the facility fifteen minutes (15) prior to the scheduled culmination time of the therapy services.

Concerns about services may be directed to Innia Pereira, Co-Owner/Manager Officer at (305) 316-9275 / (305) 952-3161 or hello@superkidsaba.com

Caregiver Initials _____ Caregiver Initials _____

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6. ADMINISTERING MEDICATION

Company employees, including clinical employees, are NOT allowed to administer any medication to clients. This includes but it's not limited to topical ointments, inhalers, feeding tubes, vitamins and/or the administration of over-the-counter medication of any kind.

Questions or uncertainty about this rule should be directed to the Operations/Human Resources manager Marcel Borges at marcel@superkidsaba.com.

Caregiver Initials _____ Caregiver Initials _____

7. PARENT/GUARDIAN CONSENT TO EXCHANGE INFORMATION

I authorize Super Kids Development Center to release or communicate necessary and pertinent information to physicians, case managers, and insurance companies for my child. Approved information may be given to, received from, and discussed with the following people directly related to my child's care. **Approved information includes written documentation and/or verbal discussion.**

Other Therapist: _____

School Name: _____

Please List any others: _____

8. CONFIDENTIALITY AGREEMENT

At Super Kids Development Center (SKDC), we respect and value the confidentiality of all our clients and their families. We appreciate being able to share our space with providers and community agencies that are interested in learning about Applied Behavior Analysis and the services we offer. To maintain these practices, we require any parent, volunteer, or visitor to commit to maintaining strict confidentiality regarding observations or information regarding other clients' needs, programming, or personal information, including, but not limited to, names, ages, diagnoses, and

treatment goal targets. I _____ agree with the following statements:

- I have reviewed and understand SKDC's Privacy Policy.

- I understand that I may come in contact with confidential information during my time at SKDC**.** As part of the condition of my time spent observing, volunteering, training, or visiting at SKDC**,** I hereby undertake to keep in strict confidence any information regarding any client, therapist, or business of SKDC or any other organization that comes to my attention while at SKDC. I will do this in accordance with SKDC's privacy policy and applicable laws.

- I also agree to never remove any confidential material of any kind from the premises or possession of SKDC without the express permission or direction to do so from the Manager or owner of SKDC**.**

Caregiver Initials _____ Caregiver Initials _____

9. ATTENDANCE AND SICK POLICY

Super Kids Development Center policy states that we require a **24-hour** notice for cancellations. After a **one-time occurrence**, a **$25 fee may be charged** (depending on the insurance) for each missed therapy appointment. We know that sickness occurs; therefore, if you think that your child is sick the night before, please call us and give us notice so we can plan accordingly. If your child is fine the next day, we will make every effort to reschedule. In the event of a cancellation, please make an effort on your part to reschedule as we want your child to benefit from his/her therapy. Additionally, if your child misses 3 consecutive days of therapy without notice, we will make every attempt to hold that slot, but cannot guarantee this with an extended absence. SKDC strives to meet the scheduling needs of every family. If your therapy time does not work for you, please let us know. The Board of Health considers the following signs to indicate communicable disease/illness:

- Vomiting/ Diarrhea
- Fever over 100 degrees
- Measles, Mumps, Chicken Pox
- Rash/Swelling
- Red, or running eyes.
- Sore Throat

Please be sure your child is symptom free for 24 hours before resuming therapy.

Caregiver Initials _____ Caregiver Initials _____

10. CANCELLATION POLICY

- Regular attendance is required for our services to be effective. Irregular attendance costs both the assigned staff member and overall program time and money. It is therefore the responsibility of the individual and his or her legal guardian to attend and participate fully in all scheduled appointments. It is expected that caregivers will always be present unless otherwise specified on the behavior support plan (e.g., for community outings). If a client is 15 minutes or more late to his session, parents will be given a lateness ticket, after 3 consecutive tickets in a year parents will be charged $25 per tardiness.
- If your child misses 3 consecutive days of therapy without notice, we will make every attempt to hold that slot, but cannot guarantee this with an extended absence.
- If Parent/primary caregiver/individual refuses to follow the mutually agreed upon treatment plan after repeated reminders and attempts to resolve barriers to implementation. If a client requests a cancellation, please make sure the BCBA, RBT and Scheduling department are informed of the cancellation by sending an email with detailed information, such as client acronym, date, time, and reason of cancellation. If a client is running late but on his/her way, the therapist is required to wait for a minimum of 30 minutes. If after 30 minutes the client has not arrived, the therapist may dismiss the session and inform all the parties about the cancellation.
- If a client is 15 minutes or more late to his session, parents will be given a lateness ticket, after 3 consecutive tickets in a year parents will be charged $25 per tardiness.

Caregiver Initials _____ Caregiver Initials _____

11. FINANCIAL AND INSURANCE POLICY

Insurance information will be needed before services begin to verify benefits. A copy of your insurance card(s) and driver's license is required. Benefits will be verified upon receipt of your insurance information, and you will be made aware of any estimated coinsurance/ copayment/ deductible/ out-of-pocket expenses. Information gained from insurance companies during verification of benefits is an estimation only and is not guaranteed. Please notify SKDC of any changes in insurance or Medicaid coverage. It is imperative that families are aware of their insurance coverage and their potential responsibilities. We will strive to keep open communication regarding insurance and payment. If you do not have insurance coverage for therapy services a payment plan may be arranged. Payment for private pay sessions is due at the time of service. Please check with the office to verify the in-network insurance providers currently. All other insurance will be billed as out- of-network (If applicable). If you utilize out of network benefits payments are due at the time of service. Unless your child has Medicaid, families are responsible for all co-pays, co- insurances, and any deductible at the time of service. SK will provide you with your paid invoices for you to submit for reimbursement though your out-out pocket benefits (if applicable)

Caregiver Initials _____ Caregiver Initials _____

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Primary insurance will always be billed first, and Medicaid will be billed secondary unless it is the primary source of payment. Prior approvals are required for ABA therapy services, Super Kids Development Center will submit for prior approvals based on need. Services will be administered after approval has been obtained.

Caregiver Initials _____ Caregiver Initials _____

If a family does not pay a bill within 30 days of receipt, there will be a 10% late fee added.

Caregiver Initials _____ Caregiver Initials _____

As in all healthcare situations, the client's family is always responsible for payment when all other sources have been exhausted. Therapy services may be put on hold or terminated if there is a problem regarding payment. There is a $39 service fee for all returned checks. Please do not hesitate to contact us regarding questions about billing/payments. We are willing to work with each client to ensure a balance between providing therapy services and addressing business issues or concerns. I have read and understood the above billing policy.

Caregiver Initials _____ Caregiver Initials _____

12. AUTHORIZATION TO BILL INSURANCE

Client Name: _____ DOB: _____

I_____, hereby give my consent to Super Kids Development Center to bill my/my child's insurance carrier for the services rendered to my child by the above-mentioned provider. In addition, I agree to pay SKDC any deductible or uncovered charge in accordance with my health care plan.

Caregiver Initials _____ Caregiver Initials _____

13. AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INSURANCE CARRIER

I understand that my express consent is required to release any health care information relating to assessment and treatment. I_____, hereby give my consent for Super Kids Development Center to release medical and other relevant information to our insurance carrier as required by my/our insurance carrier to process medical billings.

Caregiver Initials _____ Caregiver Initials _____

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14. CONSENT FOR THE RELEASE OF INFORMATION

Client Name: _____DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the supervision of Super kids Development Center.

I hereby authorize SKDC to (check all that apply):

☐Exchange information with
☐Release information to
☐Obtain information from

The following Organization/Individual regarding the client:

Name of Organization/Individual:
Address:_____ City: _____State:_____ Zip Code: _____
Phone: _____

I hereby authorize this information to be exchanged in the following manner(s):

☐Verbal only
☐Written form only
☐Both verbal and written communication

Description of information to be exchanged/released / obtained (select all that apply):

☐Education records
☐Evaluation/assessment/eligibility records
☐Medical records
☐Clinical records (including behavior analytic, physical, occupational, and speech therapies)

Others: _____

This information is to be used for diagnostic, treatment planning and continuity of care purposes only. This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing. From _____(MM/DD/YYYY) To _____MM/DD/YYYY)

Caregiver Initials _____ Caregiver Initials _____

Records Releases by: _____ Date: _____

17121 NE 6TH AVE, North Miami Beach, FL 33162
Phone : (786) 955-6224 / (305) 952-3161 Fax : (786) 364-7244
E-mail : admin@superkidsaba.com / info@crystalkidscenter.com
Superkidsaba.com

SUPER KIDS

ABA SERVICES EXPENSES

The Provider is engaged in providing Applied Behavior Analysis (ABA) services to clients, and in doing so, may incur various expenses related to the provision of these services, including but not limited to background checks, summer camp applications or fees, and other relevant expenses.

Responsibility for Expenses:

1. **Scope of Expenses:** Caregiver(s) hereby acknowledge(s) and agree(s) that any expenses incurred by the Provider to provide services to the client(s) shall be the responsibility of the Caregiver(s).
2. **Types of Expenses:** The expenses covered under this Agreement include, but are not limited to:
   - School/Summer Camp Background checks
   - School/Summer camp applications or fees
   - Any other expenses directly related to the provision of services to the client(s)
3. **Notification of Expenses:** The Provider shall notify the Caregiver(s) of any expenses incurred on behalf of the client(s) promptly and shall provide documentation or receipts as necessary.
4. **Payment Responsibility:** Caregiver(s) agree(s) to promptly reimburse the Provider for any expenses incurred within 30 days of receiving the invoice of such expenses.

General Provisions:

1. **Entire Agreement:** This Agreement constitutes the entire understanding between the Parties with respect to the subject matter hereof and supersedes all prior agreements and understandings, whether written or oral, relating to such subject matter.
2. **Modification:** Any modification to this Agreement must be made in writing and signed by both Parties.
3. **Impact on Service Provision:** Caregiver(s) acknowledge(s) that failure to reimburse the Provider for expenses may impact the services rendered to the client(s). In the event that expenses are not reimbursed within the specified time frame, the Provider reserves the right to withhold services or alter the service setting as necessary until reimbursement is received.

Caregiver Initials: _____ Caregiver Initials: _____

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15. QUESTIONS AND/OR COMPLAINTS

If any client believes his/her treatment has not been provided fairly, Super Kids Development Center will provide an advocate through the grievance process. Moreover, if client has any questions about this notice, he/she should contact us at:

Star Center
16201 NE 13th Ave
North Miami Beach FL 33162
Office: (786) 955-6224
Fax: (786) 364-7244
Email:hello@superkidsaba.com

Sun Center
17121 NE 6th Ave
North Miami Beach FL 33162
Office: (305) 952-3161
Fax: (786) 364-7244
Email: Admin@superkidsaba.com

16. ACKNOWLEDGEMENT AND RECEIPT

I acknowledge that I have received a Parent handbook with the Notice of Privacy Practices. I further acknowledge that I have reviewed and understand the information presented in this notice, including the appropriate contact information I should contact if I have any further questions, concerns, requests, or complaints regarding any of the covered subject matter.

Caregiver's name: _____ Signature: _____
Date: _____

Caregiver's name: _____ Signature: _____

Date: _____

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PARENT INVOLVEMENT POLICY

Lack of parental involvement is detrimental to a child's development and progress within an ABA program. Many research studies have demonstrated that when parents are actively involved in their child's ABA therapy program, the results are increased developmental skills, improvements in progress, reduced conflict, and stress inside of the home, and increased reports of marital satisfaction. The benefits of parental involvement in ABA therapy are varied and multiple, as are the detriments of a lack of parental involvement in ABA therapy.

The role of the ABA therapists, paraprofessionals, BCBA's, or BCaBA's, is to guide, oversee, and design programs, or to implement programs as a part of ABA therapy. The ultimate responsibility for the effectiveness, generalization and maintenance of skills taught and behaviors reduced using ABA methodologies lies with the parents.

I have read the above statements regarding the empirical support for active parental involvement in ABA therapy.

Please indicate:

☐ I WOULD

☐ I WOULD NOT

Like a research article detailing the benefits of active parental involvement to be sent to me.

Please complete:

I have the following goals for my child during the time they are engaged in ABA therapy:

I. _____

II. _____

III. _____

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I have the following goals for my child during the time they are engaged in ABA therapy.

I. _____

II. _____

III. _____

I understand that active parental involvement is necessary and critical to the success of my child's ABA therapy. I will be held responsible for the goals I have listed in this document, and the Consultant agrees to help me remain committed to these goals and modify these goals as may be necessary. Consistent and excessive instances of lack of active parental involvement on my part may result in a termination of the supervision contract, and a cessation of this working relationship. Lack of active parental involvement can include but is not limited to:

- Failure to maintain adequate communication, respond to requests for information and submit required data (in any form) in a timely manner.
- Failure to provide materials and accommodations for the ABA program (e.g., therapy room,
- materials, reinforcers, etc.)
- Failure to participate in recommended and applicable parent training and parent education as necessary for the success of the ABA program, and failure to appropriately seek out information and training about Autism & ABA
- Failure to monitor and stay on top of the child's progress in ABA program, data records, and
- anecdotal data, failure to accurately convey this information to important stakeholders.
- Failure to follow recommended treatment plans, skill acquisition programs, or behavior reduction plans as written and advised, and consistent and unapproved modifying of treatments plans, skill acquisition programs, or behavior reduction plans.

Caregiver Initials _____ Caregiver Initials _____