



54 Main Street
Sturbridge, MA 01566
info@brandiscenter.com
P: (774) 241-0001
F: (508) 462-5839

Dear Caregivers,

Thank you for your interest in the Brandis Center, Inc. We take pride in providing the highest quality, individualized Applied Behavior Analysis (ABA) services to every individual we support.

Brandis Center, Inc. services include a formal behavioral and skills assessment from a Board-Certified Behavior Analyst (BCBA). From the results of the assessment, the BCBA will write the treatment recommendations or, if necessary, make a referral. Once your insurance carrier approves the treatment recommendations, they will send us authorization to begin ABA services with the patient.

Our services include 1 on 1 direct work with your child with a Behavior Technician (BT) who is under the supervision of the BCBA. We also provide parent consultation and education, ongoing assessment and treatment, collaboration with other providers involved in your child's treatment, and the creation and modification of individualized programming that best suits your child's and family's needs.

We will assist you with verifying your insurance benefits for ABA coverage. If ABA is a covered benefit under your insurance plan, we will obtain authorization from your insurance to start services. To begin the process, please fill out and sign all required documents in this intake packet.

Please include the following if you have not done so already:

- Proof of a DSM-V Autism Diagnosis from the appropriate licensed mental health professional.
- A recent letter from your doctor recommending ABA services
- A photocopy of the front and back of your insurance card. If you plan on also using a secondary insurance plan, please include a photocopy of the front and back of that card also.
- Any assessments, evaluations, school reports, IEPs, 504 plans, and behavior plans done for the individual seeking services.
- A physical examination from a doctor no more than 1-year-old.

Please return this completed intake packet to:

Brandis Center, Inc.
54 Main St.
Sturbridge, MA 01566
P. (774) 241-0001 F. (508) 462-5839

Insurance Intake Information

Patient Information

Last:	First:	Middle:
Street:		
City:	State:	Zip:
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	D.O.B.: / /	Social: - -

Pediatric Information

Pediatrician Name:	
Phone #:	Fax #:

Responsible Party Information/Emergency Contact

Last:	First:	Middle:
Street:		
City:	State:	Zip:
Relation to Patient:	D.O.B.: / /	Phone #:
Employer:		Phone #:
Street:		
City:	State:	Zip:

Insurance Information

Primary Insurance Company:		Policy ID:
Group #:	Policy Holder Name:	
Relation to Patient:	D.O.B.: / /	
Secondary Insurance Company:		Policy ID:
Group #:	Policy Holder Name:	
Relation to Patient:	D.O.B.: / /	

History Questionnaire

1. Has the individual ever received ABA services before? YES NO

If so, what agency did the individual receive ABA services with? _____

What were the dates of ABA services? _____

2. Please fill out the boxes below indicating services that your child is currently receiving and what agency/individual is providing these services. Also, include the frequency of visits.

Speech Services:	Frequency:
Occupational Therapy:	Frequency:
Physical Therapy:	Frequency:
ABA:	Frequency:
Therapist:	Frequency:
Other:	Frequency:
Other:	Frequency:

3. Provider who gave the diagnosis of Autism Spectrum Disorder (ASD):

Provider's Name:		
Street Address:		
City:	State:	Zip:
Phone:	Date of Diagnosis:	/ /

4. Does the individual have any other mental health diagnosis, childhood illness, medical conditions, prior or current infectious diseases, or allergies? List the diagnosis and provider's information below (if the provider's name is the same as the ASD diagnosis you may leave the name blank):

Other Diagnosis (1):

Other Diagnosis:	List:	
Provider's Name:		
Street Address:		
City:	State:	Zip:
Phone:	Date of Diagnosis:	/ /

Continue on next page:

Other Diagnosis (2):

Other Diagnosis:	List:	
Provider's Name:		
Street Address:		
City:	State:	Zip:
Phone:	Date of Diagnosis:	/ /

Allergies (medications, foods, etc):

YES <input type="checkbox"/> NO <input type="checkbox"/>	List:
Additional Information (optional):	

History of Infectious Diseases:

YES <input type="checkbox"/> NO <input type="checkbox"/>	List:
Additional Information (optional):	

Childhood, Other Illnesses, or Medical Conditions:

YES <input type="checkbox"/> NO <input type="checkbox"/>	List:
Additional Information (optional):	

5. What is the primary language spoken within the individual's home? _____

Are there any other languages spoken in the home, other than the primary language?

YES NO

If so, please list: _____

6. Is the individual currently on an IEP or 504 plan? YES NO

If so, you may be asked to provide a recent copy of the 504 or IEP.

Continue on next page:

7. Does the individual receive any other professional services inside or outside of school?

YES NO

If so, please specify what behaviors the plan is/was targeting and in what setting is/was the plan used: _____

8. How did you hear about our agency? _____

9. Any additional history that you feel is relevant at this time?

Confidentiality Policy

At Brandis Center, Inc., all client records (verbal or written) will not be released or shared with outside parties unless a consent form has been signed. In such cases, the information may only be shared with the specific parties authorized on the "Consent to Release and Obtain Information".

I understand that this Confidentiality Policy is valid for the period in which the patient is in active treatment with the Brandis Center, Inc. All or any of this Confidentiality Policy is canceled upon written notification to Brandis Center, Inc. from the undersigned. A photostatic copy of this policy is as valid as the original.

I give permission for my child to take part in center-based activities located at our agency. I understand that other parents/guardians may be present and watching their own children at the same time.

Initial: _____

I give permission for my child to participate in a group setting which may be observed by other parents/guardians observing their child at the same time.

Initial: _____

The parent/guardian acknowledges that they have been informed and understand this Confidentiality Policy.

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian	Relationship	Date
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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 AND IF HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR OFFICE: (774) 241-0001

WHO WILL FOLLOW THIS NOTICE

- Any health care professional authorized to enter information into your health record.
- All divisions and/or programs of Brandis Center, Inc.
- Any volunteer we allow to help you while you are receiving services from Brandis Center, Inc.
- All employees, staff, and other personnel of Brandis Center, Inc.

YOUR HEALTH INFORMATION

At Brandis Center, Inc., (the "Agency") we understand that health information about you and your health is personal. We are committed to protecting your privacy and health information about you. We create a record of the care and services you receive at Brandis Center, Inc. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Brandis Center, Inc., whether made by this Agency's personnel or your personal physician. Your personal physician may have different policies or notices regarding the physician's use and disclosure of your health information created in the physician's office or clinic.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describe your rights and our obligations regarding the use and disclosure of that information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice that is currently in effect
- Notify you following a breach of unsecured protected health information
- Comply with any state law that is more stringent or provides you greater rights than this Notice

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed.

For Treatment: We may use or disclose health information about you to provide you with treatment or services. This includes the potential sharing of information about you to doctors, nurses, clinicians, case managers, interns or other Agency personnel, or to people outside of the Agency who are involved in your care. For example, a clinician might be treating you for a mental health problem and need to talk with one of our BCBAs/LABAs, another clinician, who has specialized training in a particular area of care. We may also disclose information about you to people outside the Agency who are involved in your health care. Electronic Exchange of Your Health Information-In some instances, we may transfer health information about you electronically to other health care providers who are providing you treatment or to the insurance plan providing payment for your treatment.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at the Agency may be approved by, billed to, and payment collected from a third party such as an insurance company. For example, we may need to give your health plan information about services you received at the Agency so your health plan will pay us or reimburse you for a session. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the service/treatment.

For Health Care Operations: We may use and disclose health information about you for Agency operations. These uses and disclosures are necessary to run the Agency and make sure that all individuals receiving services from us receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in serving you. We may also combine health information about many consumers to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, clinicians, case managers, interns, and other Agency personnel for review and learning purposes.

We may also combine the health information we have with health information from other mental health providers to compare how we are doing and see where we can make improvements in the services we offer. We will remove information that identifies you from this set of health information, so others may use it to study health care and health care delivery without learning who the specific consumers are.

Brandis Center, Inc. is a Massachusetts-designated ABA provider and is obligated under our designation to provide certain services in the Commonwealth of Massachusetts. As a result, the Commonwealth of Massachusetts may access health information related to these contracted services for obtaining treatment for clients, making payment or for its health care operations.

Appointment Reminders: We may use and disclose information to contact you as a reminder that you have an appointment.

Alternative Treatment and Benefits and Services: We may use and disclose information about you to obtain and recommend to you other treatment options and available services as well as other health-related benefits or services. **Fundraising Activities:** Should the need arise where information about you or where your participation is desired for Brandis Center, Inc. fundraising activities, the Agency would obtain your authorization. No information would be released for this purpose without your authorization.

Research: Under extremely limited circumstances, we may use and disclose health information for research purposes. For example, a research project may involve comparing the health and recovery of all consumers who received one medication to those who received another, for the same condition. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with consumers' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project; for example, to help them look for consumers with specific health needs, so long as the health information they review does not leave the Agency. We will always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at Brandis Center, Inc.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law. In Massachusetts, this would include victims of child abuse; the abuse, neglect or exploitation of vulnerable adults; or where a child under the age of sixteen is a victim of a crime; and firearm-related injuries. Under certain circumstances, the Departments within the Massachusetts Executive Office of Health and Human Services who we contract are mandated to access health information to carry out their responsibilities. We are required to disclose your health information to you and to anyone you request by written authorization to receive it.

To Avert a Serious and Imminent Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious and imminent threat to your health and safety or a serious risk of danger to an identifiable person or group of persons. Any disclosure, however, would only be to someone reasonably believed to be able to help prevent the threat.

SPECIAL SITUATIONS

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Workers' Compensation: We may release health information about you as authorized for workers' compensation or similar programs as authorized by Massachusetts law. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks: We may disclose health information about you for public health activities. These activities generally include the following: Continue on next page:

- To prevent or control disease, injury or disability;
- To report deaths;
- To report child abuse or neglect;
- To report abuse, neglect or exploitation of vulnerable adults; any suspicion of abuse, neglect, or exploitation of the elderly (age 60 or older), or a disabled adult with a diagnosed physical or mental impairment, must be reported;
- To report reactions to medications or problems with products; To notify individuals of recalls of products they may be using;
- To notify an individual who may have been exposed to a disease or may be at risk for contracting or spreading a communicable disease or condition

Health Oversight Activities: We may disclose health information to a health oversight agency, such as the Massachusetts Executive Office of Health and Human Services who we contract with, for activities authorized by law. These oversight activities include, but are not limited to, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose health information about you without your permission to the Secretary of the U.S. Department of Health and Human Services and/or Office of Civil Rights when they are conducting a compliance review, investigation or enforcement action or for a mandatory report of a health information breach.

Law Enforcement: We may disclose your health information to law enforcement officials as required by law or to comply with a court order or search warrant. We may also disclose limited information to law enforcement officials to report a crime committed on our premises or for identifying a missing person or a suspect to assist in a criminal investigation.

Legal Proceedings and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order.

Public Health Officials and Funeral Home Directors: We may release information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors thereby permitting them to carry out their duties.

Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official pertaining to care provided while you are in custody. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

USES OF HEALTH INFORMATION REQUIRING WRITTEN AUTHORIZATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. Examples of this may include disclosures to lawyers, employers, the Massachusetts Office of Disability Services, or others who you know, but who are not involved in your care.

Additionally, uses and disclosures of protected health information for our fundraising activities, marketing purposes, and disclosures that constitute a sale of protected health information require authorization. Also, Psychotherapy notes maintained by your treating provider can only be disclosed with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the services that we provided to you.

Right to Review and Copy: You have the right to review and copy health information that may be used to make decisions about your care. This may include both health and billing records. We must respond to your request within thirty days of our receipt of your request unless we notify you in writing during this period of reasons that delay our response. If so, we may take up to an additional thirty days or a total of sixty days from our receipt of your request to respond to it.

Continue on next page:

To review and copy health information that may be used to make decisions about you, you must submit your request in writing to Brandis Center, Inc. If you request a copy of the information, we may charge a reasonable, cost-based fee for copying, mailing, or supplies associated with your request. If you seek an electronic copy in a specific form or format of any portion of your health record, and the Agency is unable to readily produce the copy in that form or format, we will work with you to provide an alternative form or format for the electronic copy.

We may deny or limit access to your request to inspect and copy only in certain very limited circumstances. Should you be denied or provided only limited access to your health information because it was determined that permitting you access might endanger or substantially harm you or another person, you may request that the decision be reviewed. The Brandis Center, Inc. will choose a different health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Agency.

To request an amendment, your request must be made in writing and submitted to Brandis Center, Inc. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support that request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the designated record set kept by or for the Agency;
 - Is not part of the information which you would be permitted to inspect and copy; or,
 - Was determined to be accurate or complete by the Agency.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of health information about you that was required by law and/or were not authorized by you. The list of disclosures will not include disclosures made for the purposes of treatment, payment for treatment services, or health care operations related to the treatment services.

To request this list or accounting of disclosures, you must submit your request in writing to Brandis Center, Inc. Your request must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to your request unless your request is to limit disclosures to a health plan for the purpose of carrying out payment or health care operations that are not otherwise required by law and you or someone on your behalf other than your health plan has paid for those services in full at the time the health services are provided. However, if we do agree with a requested restriction or limitation, we will comply with your request unless the information is needed to provide you with emergency treatment.

You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member. For example, you could ask that we not use or disclose information about a therapy session you received.

To request restrictions, you must make your request in writing to Brandis Center, Inc. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Brandis Center, Inc. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of the current notice at any time. To obtain a paper copy of this notice, please ask our Office Personnel.

SECURITY OF HEALTH INFORMATION

We have in place appropriate safeguards to protect and secure the confidentiality of your health information. Due to the nature of community-based human service practices, Agency representatives may possess your health information outside of the Agency. In these cases, Agency representatives will ensure the security and confidentiality of the information in a manner that meets Agency policy, and State and Federal Law.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the Brandis Center, Inc. facility. The notice will contain an effective date. Should we make a material change to this notice, we will, prior to the change taking effect, publish an announcement of the change at every Agency facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Brandis Center, Inc. or with the Secretary of the Department of Health and Human Services. To discuss a complaint with Brandis Center, Inc., call (774) 241-0001. All formal complaints must be submitted in writing to Brandis Center, Inc. 54 Main St., Sturbridge, MA 01566. You will not be penalized for filing a complaint.

The Secretary of the Department of Health and Human Services can be contacted through their regional office at Office of Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building – Room 1875, Boston, Massachusetts 02203, voice phone (800) 368-1019, fax (617) 565-3809, TDD (800) 537-7697.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the Notice of Privacy Practices statement of Brandis Center, Inc.

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian	Relationship	Date
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Financial Policy & Patient Responsibility

IT IS THE PATIENT’S RESPONSIBILITY:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co- payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physicians (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment at the time of the service.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate claims payment by contacting their insurance carrier when claims have not been paid.
- To notify our office immediately when your insurance plan or carrier has changed.

IT IS BRANDIS CENTER INC. RESPONSIBILITY:

- To provide quality therapy services.
- To file insurance claims as a courtesy to the patient. A 60-day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance, as applicable by law.

CANCELLATION NOTICE: If a cancellation is necessary, we request that you notify us at least 24 hours in advance. This allows us to potentially reschedule a make-up session, or open a slot for another patient who may need our services. Non-emergency cancellations made **within 24 hours** may result in a cancellation fee of up to **\$100** per appointment missed, or as allowed under your medical insurance. This fee will be sent via mail or email by Brandis Center Inc. to the patient and/or parent/guardian on file.

SCHEDULED APPOINTMENTS:

We understand that delays can happen, however, it is imperative that everyone arrives on time. If a client and/or family is 15 minutes past their scheduled time we will have to reschedule the appointment.

ACCOUNT BALANCES:

We will require that clients with self-pay, copay or coinsurance balances pay their account balances to zero (0) prior to receiving further services by our practice. Clients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to our office personnel with whom they can review their account and concerns. Clients with balances over \$100 must make payment arrangements prior to future appointments being made.

ACKNOWLEDGEMENT:

I have read and understood the above Financial Policy & Patient Responsibility. I understand that, regardless of my insurance claim status or absence of insurance coverage. I am ultimately responsible for the balance on my account for any services rendered, as applicable by law.

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian	Relationship	Date
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Release of Medical Information and Assignment of Benefits for Medical Billing

I authorize the release of medical information necessary for filing health insurance claims, authorization requests, and/or to obtain benefits & eligibility status for me by Brandis Center, Inc.

I also authorize my insurance carrier(s) to make payment directly to Brandis Center, Inc.

I understand that it is my responsibility to update Brandis Center, Inc. immediately with any changes to my insurance policy, benefits, or carrier.

Insurance Information

Primary Insurance Company:		Policy ID:
Group #:	Policy Holder Name:	
Secondary Insurance Company:		Policy ID:
Group #:	Policy Holder Name:	
Relation to Patient:	D.O.B.: / /	

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Relationship

Date

Infection Control Policy

The nature of ABA services necessitates that providers are aware of illnesses in the homes that they visit and the patients they are exposed to. For that reason, it is extremely important that you make Brandis Center, Inc. and its employees aware of any infectious diseases your child, yourself, or others in your home may have been exposed to.

Brandis Center, Inc. will take proactive steps to protect the workplace in the event of an infectious disease outbreak. It is the goal of Brandis Center, Inc., during any such time period, to strive to operate effectively and ensure that all essential services are continuously provided and that patients and employees are safe.

Brandis Center, Inc. is committed to providing authoritative information about the nature and spread of infectious diseases, including symptoms and signs to watch for, as well as required steps to be taken in the event of an illness or outbreak.

Preventing the Spread of Infection

Brandis Center, Inc. will ensure a clean workplace, including the regular cleaning of objects and areas that are frequently used, such as bathrooms, break rooms, social group rooms, sensory rooms, door handles, and railings.

Brandis Center, Inc. will monitor and coordinate events around an infectious disease outbreak, as well as create work rules that could be implemented to promote safety through infection control.

We ask all individuals to cooperate in taking steps to reduce the transmission of infectious diseases in the workplace. The best strategy remains the most obvious—frequent hand washing with warm, soapy water; covering your mouth whenever you sneeze or cough; and discarding used tissues in wastebaskets. We provide alcohol-based hand sanitizers throughout the workplace and in common areas.

Unless otherwise notified, normal business hours will remain in place. Individuals who believe they may face particular challenges attending sessions during an infectious disease outbreak should take steps to develop any necessary contingency plans. Contact Brandis Center, Inc. to discuss plans as necessary.

Temperature & Health Screening

Temperature screening at Brandis Center, Inc. may or may not take place depending on the guidance of local and state agencies. It is always the responsibility of individuals to self screen at home before attending sessions. Health Screening forms are currently required to be filled out by patients and employees before the start of each session. This will continue until further notice.

Telehealth Services

Telehealth Services may be available to you depending on the level of care needed and by authorization of your insurance carrier. Contact Brandis Center, Inc. regarding a request for telehealth services.

Staying Home When Ill

Even with the best of intentions, individuals often report to sessions even though they feel ill. During an infectious disease outbreak, it is critical that individuals do not report to Brandis Center, Inc. while they are ill and/or experiencing the following symptoms: [Examples include fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills, and fatigue]. Currently, the Centers for Disease Control and Prevention recommends that individuals with an infectious illness such as the flu remain at home until at least 24 hours after they are free of fever (100.4 degrees F) or signs of a fever without the use of fever-reducing medications. Patients or Employees who report to the session will be sent home in accordance with current health guidelines.

Requests for Medical Information and/or Documentation

If you are out sick or show symptoms of being ill, it may become necessary to request information from you and/or your healthcare provider. In general, we would request medical information to confirm your need to be absent, to show whether and how an absence relates to the infection, and to know that it is appropriate for you to return to sessions. As always, we expect and appreciate your cooperation if and when medical information is sought.

Continue on next page:

Confidentiality of Medical Information

Our policy is to treat any medical information as a confidential medical record. In furtherance of this policy, any disclosure of medical information is in limited circumstances with supervisors, managers, first aid and safety personnel, and government officials as required by law.

Social Distancing Guidelines

Social Distancing Guidelines will be put in place, as needed, in accordance with local and state agencies.

Face Coverings

Face Covering Guidelines will be put in place, as needed, in accordance with local and state agencies.

Brandis Center, Inc. may amend this policy at any time to ensure compliance with all local and state guidelines.

By signing this document I am acknowledging that I have reviewed and gained understanding of Brandis Center, Inc. Infection Control Policy.

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Relationship

Date

Video Surveillance and Employee Rights Policy

This policy is designed to notify parents and guardians of patients attending Brandis Center, Inc. that our premises are under continuous 24-hour video-only surveillance. This document also outlines the rights of our employees regarding surveillance in a patient's home.

Part I: Office Surveillance

1. **Purpose of Surveillance:** The surveillance system is installed to ensure the safety and security of all individuals within our facility, deter potential unlawful activities, and aid in the identification of individuals involved in any incidents at Brandis Center, Inc.
2. **Video-Only Surveillance:** Our surveillance system captures video only. It does not record audio, and conversations or other audible data will not be recorded or monitored.
3. **Location and Exempt Areas:** Surveillance cameras are positioned in various locations within our facility. Areas with a reasonable expectation of privacy, such as restrooms or changing areas, are not under surveillance.
4. **Data Management:** Video footage is stored securely in line with our privacy policies and HIPAA regulations. Access to the surveillance footage is strictly limited to authorized personnel only.

Part II: Employee Rights in a Patient's Home

1. **Respecting Privacy:** We respect the privacy of our employees when they are providing services in a patient's home. While we understand that home surveillance systems are used by families for their security and for monitoring the wellbeing of their family members, these should not infringe upon our employees' rights to privacy.
2. **Surveillance Disclosure:** If surveillance equipment is in use at a patient's home, it is the responsibility of the family to inform the visiting employee about the presence, extent, and purpose of the surveillance.
3. **Video and Audio Recording:** Any video and/or audio recording of our employees without their explicit knowledge and consent is prohibited. Any concerns about the services provided should be communicated directly to our management.

By signing this policy, you acknowledge that you understand and accept the terms of the Video Surveillance and Employee Rights Policy as outlined above.

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Relationship

Date

Availability Form

Based on medical necessity, a Brandis Center, Inc. LABA/BCBA will recommend/prescribe a number of hours of ABA services per week. Please indicate below the days and times your child is available for ABA services.

We understand that schedules may change throughout the year, however, this Availability Form gives us a general idea as to when your child is available. We ask that you give us at least 30 days' notice of schedule changes. **Understand that significant changes or non-emergency cancellations may result in staffing changes and/or a pause in services.**

**Indicate a block of time by making a checkmark in each box for each day available.
Leave a day of the week blank if it is unavailable.**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Block 1 8:30AM - 12:30PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Block 2 1:00PM - 3:00PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Block 3 3:30PM - 6:00PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Time From: _____ To: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Relationship

Date

Cancellation & Call-Out Policy

At Brandis Center, Inc., our aim is to provide consistent, high-quality services to our patients. Unexcused or non-emergency cancellations can disrupt service provision and impact the efficacy of the treatment program. This policy outlines our terms regarding service call-outs and cancellations.

Cancellation Notice: If a cancellation is necessary, we request that you notify us at least 24 hours in advance. This allows us to potentially reschedule a make-up session, or open a slot for another patient who may need our services. Non-emergency cancellations made **within 24 hours** may result in a cancellation fee of up to **\$100** per appointment missed, or as allowed under your medical insurance. This fee will be sent via mail or email by Brandis Center Inc. to the patient and/or parent/guardian on file.

Unexcused Cancellations: Cancellations are considered 'unexcused' if they do not fall under emergency circumstances and/or are made without giving a minimum of 24 hours' notice.

Emergencies: We understand that unexpected circumstances may arise. Emergencies, severe illness, or other serious matters will be taken into consideration on a case-by-case basis.

Repeated Cancellations: Patients with six (6) unexcused cancellations within a six-month period may have their services temporarily suspended. This decision will be made on a case-by-case basis and will be communicated in writing to the parent or guardian. Furthermore, Brandis Center, Inc. reserves the right to discuss the potential for discharge from the service. This will be a last resort, taken only after all other avenues have been exhausted and when we believe that continued cancellations are severely impacting the treatment's effectiveness.

Procedure: Patients who are unable to attend service must notify our office by calling (774) 241-0001, email or call their BCBA/LABA, or by notifying our main office via email info@brandiscenter.com. Text message communication is not considered an acceptable method of canceling services, and does not guarantee our office will be aware of the cancellation.

By signing this policy, you are indicating that you fully understand the **Cancellation & Call-Out Policy** and agree to these terms. If you have any questions regarding this policy, please reach out to our office at (774) 241-0001.

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Relationship

Date

Contact and Communication Policy

At Brandis Center, Inc., we value our relationship with patients and their families. To ensure effective communication while also respecting the work-life balance of our staff, we have outlined the following contact and communication policy.

1. **Contact Hours:** Parents/guardians are kindly requested to contact their designated Board Certified Behavior Analyst (BCBA), or therapist during normal business hours only (9:00 AM - 5:00 PM), unless it is a bona fide emergency. These hours may be subject to change, in which case parents/guardians will be notified in advance.
2. **Emergencies:** In the event of a bona fide emergency, it is acceptable to contact your BCBA/LABA outside of normal business hours. However, please remember that if you believe there is an immediate threat to health or safety, it is crucial to dial 911 or go to the nearest emergency room.
3. **Response Time:** Parents/guardians should not expect a callback or response outside of business hours unless the situation is identified as a bona fide emergency. Any messages or inquiries received outside of business hours will be addressed on the next business day.
4. **Communication Channels:** Please communicate through the appropriate and established channels, which include official phone lines and email addresses. Personal contact information should not be used unless otherwise agreed upon by all parties. Understand that any such agreements may be revoked at any time.
5. **Respectful Communication:** We request that all communications remain respectful. While we understand that concerns regarding a patient can be stressful, it is essential to maintain a professional and courteous manner.

By signing this policy, you are indicating that you fully understand and agree to the terms of the Contact and Communication Policy as outlined above.

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Relationship

Date

Patient Drop Off & Pickup Policy

The safety of the children under our care at Brandis Center, Inc. is our highest priority. We have therefore developed the following policy regarding Patient Drop Off & Pickup.

1. **Authorized Individuals:** Only individuals authorized by the patient's parent or legal guardian are allowed to drop off or pick up the patient from our office. These individuals may include parents, legal guardians, other family members, or designated caregivers.
2. **Written Consent:** We require written consent from the patient's parent or legal guardian listing all individuals who are authorized to pick up the patient. This list should be provided to us upon initiation of services and can be updated as needed. Any changes to this list must also be provided in writing.
3. **Identification:** Authorized individuals, who may be unknown to our staff, may be required to provide valid photo identification at the time of pickup. This is crucial for the safety of our patients and to ensure that the individual picking up the patient is indeed authorized to do so.
4. **Unlisted Individuals:** In case an unlisted individual comes to pick up the patient, they will not be allowed to do so without prior written and verbal authorization from the patient's parent or legal guardian.
5. **Emergencies:** In the case of an emergency where an unlisted individual must pick up the patient, we require both a verbal and written authorization from the patient's parent or legal guardian.

By signing this policy, you are indicating that you fully understand and agree to the Patient Drop Off & Pickup Policy.

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Relationship

Date

Current Authorized Individuals:

1. Person's Name _____ Relationship to patient _____
Contact Phone # _____
2. Person's Name _____ Relationship to patient _____
Contact Phone # _____
3. Person's Name _____ Relationship to patient _____
Contact Phone # _____

Parent Training Session Compliance Policy

Brandis Center, Inc. recognizes the significant role that parents and guardians play in the progress and development of our patients. As such, parent training sessions are a crucial component of our service. This policy outlines the obligations of parents/guardians regarding these training sessions.

1. **Parent Training Sessions:** Our Board Certified Behavior Analyst (BCBA) may recommend parent training sessions. These are designed to equip parents/guardians with the necessary knowledge and skills to effectively support their child's treatment and development.
2. **Attendance Requirement:** Parents/guardians are required to attend all recommended training sessions. Understand that most medical insurance companies require on-going training as part of the patient's treatment plan. Failure to attend these sessions without a valid reason may impact the child's progress and the effectiveness of the treatment plan.
3. **Rescheduling:** We understand that unforeseen circumstances can occur. If you are unable to attend a scheduled training session, please notify us at least 24 hours in advance to reschedule the session.
4. **Repeated Non-Compliance:** Consistent non-compliance with attending the recommended training sessions will be regarded seriously. If a caregiver constantly cancels or reschedules scheduled training sessions without a valid reason, a review meeting will be held to discuss the potential consequences, which may include discharge of services.
5. **Discharge of Services:** In cases where non-compliance with training sessions continues despite previous discussions and warnings, we may have to consider discharging the patient from our services. This step will be taken as a last resort when we believe that the effectiveness of the treatment program is being severely compromised.

By signing this policy, you are indicating that you fully understand and agree to the Parent Training Session Compliance Policy.

Printed name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Relationship

Date