Compass Behavioral & Developmental Consultants, LLC.
3121 N Oak Street Ext
Tel: 800-832-9419 Fax: 1-855-859-1671
Email: info@compassaid.com
www.compassaid.com

Patient Registration Form

Thank you for selecting Compass Behavioral & Developmental Consultants, LLC to help you meet the needs of your child.

The attached packet of information will help inform you about Compass BDC policies and procedures and allow you time to gather information prior to your intake appointment. This information will be shared with the BCBA assigned to your case, should you proceed with ABA therapy, prior to your initial meeting with them. In each instance the BCBA is responsible professionally for all services provided to you and your child.

Thank you for the trust that you are placing in us to assist you and your family. We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information that we have the better able we will be to assist you and your family. If at any time in this process you have any questions, please contact us.

We look forward to meeting you and your child, Compass Behavioral & Developmental Consultants, LLC.

Please return Intake Packet to us prior to initial appointment.

Fax: 855-859-1671

Current Locations:

- Valdosta, GA (surrounding areas)
  3121 N Oak St Extension
  Tel: 800-832-9419 ext 1
  Email: officev@compassaid.com

- Hinesville, GA (surrounding areas)
  740 East General Stewart Suite 108
  Tel: 800-832-9419 ext 2
  Email: officeh@compassaid.com

- Thomasville, GA (surrounding areas)
  602 Victoria Place Suite A
  Tel: 800-832-9419 ext 3
  Email: officet@compassaid.com

- Warner Robins, GA (surrounding areas)
  402 Corder Rd Suite 400
  Tel: 800-832-9419 ext 4
  Email: officew@compassaid.com

- Bluffton, SC (surrounding areas)
  119 Palmetto Way Suite B
  Tel: 800-832-9419 ext 5
  Email: officesc@compassaid.com

Getting Started with ABA Therapy

1. Complete Intake Packet and send it back to us

   - ☐ Insurance Information with Insurance Card, front and back (if applicable)
   - ☐ Fee Schedule
   - ☐ Referral for ABA from Child's Primary Care Doctor or Specialty Provider
   - ☐ Psychological Evaluation with Diagnoses
   - ☐ Signed HIPPA Service Agreement and Consent Form (included in this packet)
   - ☐ Patient Confidentiality Contact Form (included in this packet)
   - ☐ Request/Authorization to Release Confidential Medical Records & Mental Health Records (included in this packet)
   - ☐ Documents of prior ABA (Optional –if available/applicable)
   - ☐ Current IEP/IFSP/504 (Optional –if available/applicable)

2. Appointment will be set for Initial Assessment with BCBA/BCaBA/QASP to develop treatment goals where your child will be assessed in person. At that time BCBA/BCaBA/QASP will advise you whether other assessment tools would be utilized such as VB-MaPP, ABLLS-R, PDDBI, PEAK.

3. After Assessment is complete please allow up to 2 weeks so that we can submit BSP to your insurance for pre-authorization of ongoing services.

4. After we receive pre-authorization, our office staff will contact you to arrange ongoing services.

5. Arrangement of schedule for In-Home/Clinic Therapists and Supervisors visits will follow within a week or two after initial BSP is completed and authorization obtained.

6. Services will include direct ABA Therapy, Plan Modification, Parent Training and Supervision of a Technician. Every 3-6 months a progress update will be submitted to your insurance. At this time parents/guardians will assist with PDDBI and other required evaluations and doctor referrals, if required.

7. Please contact our office if you have any questions and we will do our best to guide you.

INSURANCE REIMBURSEMENT FORM

Date:_____Client's Name:_____D.O.B_____

☐ Please check here if you have MEDICAID

PRIMARY Insurance

Subscriber Name:_____D.O.B._____M___F_____

Spouse Name:_____D.O.B._____M___F_____

Insurance Company:_____ Phone#:_____

Identification Number:_____(full SSN of Sponsor for Tricare)

Group/Plan Number: _____

Employer: _____

Insured's Phone#:_____ Insured's Email: _____

Please Let Us Know how you heard about Compass:

*Please provide us with a copy of the front and back of your insurance identification cards.

SECONDARY Insurance (if applicable)

Subscriber Name:_____D.O.B._____M___F_____

Spouse Name:_____D.O.B._____M___F_____

Insurance Company:_____Phone#:_____

Identification Number:_____(full SSN of Sponsor for Tricare)

Group/Plan Number: _____

Insurance Verification (For Office Use Only)

Deductible: Individual.$_____/Fam.$_____AmountMet:Individual.$_____/Fam.$_____

Co-Pay:$_____Co-insurance:_____% LifetimeMax:$_____# of ABA Units:# of ABA Units Used:

Does treatment needtobe pre-certified? _____

Verifiedby:_____Date: _____

FINANCIAL & BILLING POLICY AGREEMENT

New patients approved for ABA Therapy services are responsible for any and all charges not paid for by healthcare insurance payers (private of public). By signing this client agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Compass BDC LLC for the services we provide to you, our valued customer.

Compass is responsible for providing quality therapy to the child and therefore, the child's parent (or guardian) is responsible for all charges incurred. Due to the many changes in insurance policies, it is no longer a simple task to interpret each and every policy. Although we try to stay aware of any changes, it is not always possible. It is your responsibility, as the subscriber, to know and understand your individual coverage and to immediately notify us if any changes occur.

*All services are subject to pre-authorization and insurance claim processing.

Insurance: Compass is committed to helping maximize each child's insurance benefits. Insurance policies vary greatly, therefore, owing to the complexity of insurance contracts; we can only estimate benefits in good faith. Compass will contact your insurance carrier for a "quote of benefits" and will obtain necessary pre-authorizations, but coverage cannot be guaranteed.

In the event the insurance company does not provide payment within the agreed amount of time or denies the payment, the balance becomes that of the financially responsible party. To avoid any payment delays from your insurance carrier, please let Compass know of any and all updated information regarding your plan and ABA Therapy coverage. Please let us know immediately if you receive a new insurance card or if your child is covered under new or additional insurance. The responsible party will be billed for services not covered or denied if Compass is not notified in a timely manner of any changes. In addition, Compass has the right to suspend services until new insurance is verified and/or necessary pre-authorizations are in place.

If the responsible party wishes to continue services before insurance is verified and/or pre-authorization is in place, the responsible party will be required to privately pay for those services at the end of each week. If you have questions regarding our financial policy, please do not hesitate to discuss them with us. For your convenience, we accept Master Card, Visa, Cash, HSA Cards, Checks, and have safe and convenient payment online at: compassaid.com/payment

Private Pay: Families who do not have insurance coverage for ABA may choose to pay privately for ABA Therapy. Services are billed in advance on a mon-to-month basis for pre-scheduled ABA Therapy sessions. Pre-paid fees are non-refundable in absences. Our fees are comparable usual and customary fees in the area.

Cancellation: Compass schedules a 1:1 ABA Technician to work specifically with your child for the duration of his/her scheduled sessions. Any cancelations require at least a 24-hour notice so our staff's schedule may be adjusted accordingly. We understand that there may be days when your child is ill and will need to stay home. Therefore, Compass BDC LLC can grant one (1) sick day per month at zero penalty. Any additional absences within the same month (with less than 24-hour notice) will be

charged at $50-100 per day. Excessive cancellations may result in dismissal of services or reassignment of therapists. Any instance of a week or more vacation may result in reassignment of therapists upon return. Please see the "Therapy Attendance Policy" and the "Cancellation & Late Policy Fees" for further information.

Payments: All copays are due at the date of service. Being that we work in an environment with children we will email statements for patient responsibility weekly. Weekly invoices are due within two (2) calendar days of invoicing for continued services. Payments can be made directly through the website: compassaid.com/payment

Credit Card on File for Pre-Payment: To ensure a smooth billing process, Compass requires a credit card to remain on file which will be automatically billed after six (6) days of invoicing, along with a $25 late fee. A $35 fee will be charged for declined payments, if another form of payment is not provided within 24-hours of notification of the declined payment. If a payment is declined, Compass may suspend services until payment is made. You may choose to pre-pay 30 days in advance without having a Credit/Debit card on file for reoccurring charges.

NOTE – Credit card on file for pre-payment is only required if there is patient responsibility.

Collection Fees: Fees incurred to collect payments will be billed to and payable by the Responsible Party. This includes attorney fees and court costs.

Note to Separated or Divorced Parents: Compass will not keep separate accounts to accommodate separated or divorced parents who share financial responsibility.

I understand and agree that I am responsible for the payment of all charges incurred, in the time frames described above, regardless of any insurance coverage or other plans available to me. Additionally, I understand and agree to pay any and all collections, costs, and/or attorney's fees if any delinquent balance is placed with an agency or attorney for collection, suit, or legal action. I also acknowledge that confidentiality is waived in matters involving collections and the sharing of information sufficient to pursue recovery of debts owed.

Printed Name of Responsible Party:_____ SSN:_____

Signature of Responsible Party:_____ Date:_____

Relationship to Client:_____

Credit Card Number:_____

Card Expiration Date:_____ Security Code:_____

Credit Card Holder Name:_____ Card Type:_____

Please check here if you would like to prepay for Co-Pays/Deductible Services – YES ☐

CLIENT INFORMATION

PLEASE PRINT _____

Person Completing Form: _____ Relationship to Child: _____

Child's Name: _____ D.O.B. _____ M _____ F _____

Home Address: _____
Street

_____ _____ _____
City State Zip

Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Parent/Guardian Contact Information:

Name: _____ Relationship to Child: _____

Email: _____ Cell: _____

Home: _____ Work: _____

Occupation: _____ DOB: _____

Address (if different from child): _____

Preferred form of contact ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Name: _____ Relationship to Child: _____

Email: _____ Cell: _____

Home: _____ Work: _____

Occupation: _____ DOB: _____

Address (if different from child): _____

Preferred form of contact ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Responsible Party Contact Information (if different from Parent/Guardian):

Name: _____ Relationship to Child: _____

Email: _____ Phone #: _____

MEDICAL HISTORY

Is your child currently in good health? YES ☐ NO ☐

Diagnosis	ICD-9 or DSM codes	Diagnosing Doctor	Date Diagnosed

Please List Child's current Medications:

Medication	Dosage	Purpose	Prescribing Doctor

Please list ALL allergies your child has: _____

Other medical conditions/information: _____

_____

EDUCATIONAL HISTORY

School Name:_____System:_____Grade:_____

Is your child in school a full day? _____If not –how many hours? _____

Current Teacher(s): _____

Does your child's teacher have concerns about him/her?: _____

_____

Please list special education services your child receives (IEP/504/behavior plan): _____

_____

Has your child ever received ABA? If yes, how long, and when was the last date of services:

_____

Does your child receive SLP/OT/PT services at school and outside of the school?

Provider	How many hours at school?	Hours outside of school?	Total hours
SLP			
OT			

Communication Skills:
Primary method of communication: □ Picture Communication □Sign Language □ACC □Verbal □Gestures

Comments: _____

_____

_____

_____

Barriers to Communication:
□ Impaired Articulation □Impaired Mand □Impaired Tact □Echoic
□ Scrolling □ Impaired Echoic □ Impaired Intraverbal □Prompt Dependent □Weak Speaker Skills
□Weak Listener Skills □Weak Interpretation of Non-Verbal Communication

Comments: _____

_____

_____

_____

Social and Play:
Does your child seek out interaction with: □Parents □ Siblings □ Other adults □Peers
Does your child play: □ Independently □ Next to other children □ Only by him/herself?
What play skills does your child have? □ Plays with toys appropriately □ Plays easy card games appropriately
□ Plays board games □ Takes turns □ Follows rules of the game □ Keeps score
Comments: _____

_____

_____

_____

Behavior:
□ Physical stereotypical behavior □ Verbal stereotypical behavior □ Perseverations
Comments: _____

_____

_____

_____

Challenging Behavior:
□ Physical aggression □ Self-injurious behavior □ Running □ Verbal aggression □ Yelling or screaming
□Other _____

Triggers (if known): _____

PARENT/FAMILY PRIORITIES & PREFERENCES

Top three areas/goals you would like to see change for your child in the next 6 months:

1.

2.

3.

BEST TIME FOR THERAPIES

Preferred schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday
Time *					
Location**					

*Usually sessions at the clinic or in the home are 2-3 hours; at school/daycare sessions might be longer but are still at least 2 hours. Our hours for sessions are usually 9am to 7pm weekdays. Based on need we may be able to accommodate earlier, later, or weekend sessions.

** We are providing services in various locations based on child's needs, such as clinic, family home, school, and daycare and afterschool programs.

CONSENT AND RELEASE

I hereby consent to treatment by, and authorize insurance benefits to be paid directly to, Compass Behavioral & Developmental Consultants LLC. I agree that I am responsible to pay 1) for services not covered by my insurance company, 2) co-payments and deductibles, and 3) any expense associated with the collection of a debt owed to them by me (i.e. Attorney fee, court cost or collection agency fee). I also consent to the release of pertinent medical information to my insurance carrier(s) for the purpose of processing health care claims.

X_____ _____ _____

(Signature of Responsible Party) (Date) (Printed Name/Relationship)

PRIVATE INSURANCE RECIPIENT OR PRIVATE PAY

Compass Behavioral & Developmental Consultants LLC. provides ABA therapy and may or may not be in network with your insurance. I understand that Insurance Benefits will be verified prior to ABA Therapy however they are not guarantee of coverage and payment from the Insurance. They are estimate of services. I also understand that all BT and RBTs and BCaBAs work directly under the Clinical supervision of a BCBA and BCBA-D following state and BACB guidelines.

X_____ _____ _____

(Signature of Responsible Party) (Date) (Client Name)

HIPAA AND SERVICE AGREEMENT

Your signature(s) below indicates that you have received HIPPA and Privacy Information Notices and that I have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

X_____ _____ _____

(Signature of Responsible Party) (Date) (Client Name)

INFORMATION SHARING AND HIPPA

I give consent to my Therapist, as a contractor for Compass Behavioral & Developmental Consultants LLC to discuss my child's progress and behaviors with their supervising BCBA/BCaBA, their coworkers, and/or any relevant school personnel, speech therapists, occupational therapists. Etc. in the spirit of obtaining new ideas and skills or in an effort to share information that will be beneficial to either party in providing the best possible services for the child.

X_____ _____ _____

(Signature of Responsible Party) (Date) (Client Name)

PERMISSION TO USE WEB SUPERVISION

I give permission and consent for Compass BDC and the staff to use web cam while in session with my child and/or myself during the time my child is enrolled in services, only for accessional remote supervision by a BCBA/BCaBA. I understand that sessions will not be recorded and disbursed, and my child's privacy will be protected.

Child's name:_____Date of birth: _____

X_____ _____ _____

(Signature of Parent/Guardian) (Date) (Printed Name)

CONFIDENTIAL RELEASE FORM

I,_____, do hereby authorize: Compass Behavioral & Developmental Consultants LLC., including all employees, to RELEASE TO and OBTAIN FROM information from the record of

_____ _____
(Print Child/Client Name) (Date of Birth)

The information that may be released includes:

- ☐ Physical Examination
- ☐ Birth Record
- ☐ Medical Examination
- ☐ Psychological Examination
- ☐ Psychosocial History
- ☐ IEP/IFSP
- ☐ Progress Notes
- ☐ Summary of Treatment to Date
- ☐ Discharge Summary
- ☐ After Care Plan
- ☐ Medication Record
- ☐ Education Record

I understand that I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose(s) specified above.

I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon), by written, dated, communication to the Office of Compass Behavioral & Developmental Consultants LLC.

X_____ _____
(Signature of Parent/Guardian) (Date)

THERAPY ATTENDANCE POLICY

As a preventative reminder, please consider that if you qualify for ABA Therapy with Compass Behavioral & Developmental Consultants LLC, it is important to be consistent in attending therapy sessions.

Why is consistent attendance important?

Client's need regular contact with the therapist familiar with their individual needs. This usually increases the rate of progress on individualized goals. In the long run, this is the most cost-effective thing to do because the goals will be reached sooner (assuming the child is practicing between sessions).

As professionals trained in providing specialized therapies, we ethically are to recommend what we believe is needed for the client based on assessment and observation. It is important for families to try as much as possible to follow our recommendations about how much therapy is needed.

Insurance companies expect their participants to attend recommended treatment on a consistent basis because following the course of treatment recommended for the client is part of efficient use of benefits. We must document attendance as a part of our records and progress reports.

The therapist has set aside time in his/her schedule to be available for you or your child. He/she usually cannot schedule anyone else for your time. Therapists prepare for your visits prior to appointments. Frequent or late cancellations result in the therapist spending unnecessary time in preparation.

Attendance Policy

Cancellation must only occur in the case of a true illness (fever or sick enough to miss school or go to the doctor) or family emergency. As with other professional services, you will be charged $50-$100 depending on hours of scheduled treatment that are missed (outlined below).

One sick day will be allotted per month and make up sessions will be offered the same week of the missed session.

Therapy must be cancelled 24 hours in advanced or the client will be charged for the missed appointment. Please remember that this fee is not billable to the insurance company, so it will be the responsibility of the family.

Vacations require at least 2 weeks advanced notice, with more notice given whenever possible**.**

Late Drop-off Policy

Please notify Compass as soon as possible if you are going to be dropping your child off late. We reserve your ABA therapist to work with your child one on one. Sessions that begin late due to delays on the part of the family cannot be extended or rescheduled as we cannot guarantee ABA therapist availability at other times. In situations where a family has dropped their child off late 3 or more times in a month, we will call a meeting to consider rescheduling appointment times. In extreme circumstances we may be required to terminate services due to your insurance provider's policies.

Late Pick-up Policy

Please notify Compass as soon as possible if you know you are going to be late to pick up your child. If you anticipate that you will be more than 15 minutes late, it is recommended that you make alternate arrangements for a timely pick up.

At 5 minutes late to pick-up, the provider will call parent/guardian to assess the situation. If no contact is made by 15 minutes after scheduled pick-up, the provider will attempt to contact those listed on the emergency contact list. If we are unable to confirm an authorized pick-up within 1 hour after pick-up time, the appropriate authorities will be contacted so they can further investigate the circumstances.

Consistent cancelations will result in reassignment of therapies.

CANCELLATION & LATE POLICY FEES

In order to best provide services, Compass BDC, LLC adheres to the following fee schedules for our cancellation and late policy:

Situation	Fee
No Call - No Show: *Any session that does not start within 10 minutes of scheduled time and family has not contacted Compass BDC, LLC prior to scheduled time.*	$100
Cancellation: *Any session that is cancelled with less than 24 hours' notice.*	$50
Late Drop-Off: *Family has informed Compass BDC, LLC that child will be present but more than 10 minutes after session start time. After 10 minutes, cancellation charge applies.*	10+ mins: $50
Late Pick-Up: *Family picks up child 10 or more minutes after scheduled session end time.*	10+ mins: $50

I have read this information regarding the importance of therapy attendance and understand that I will be charged for late cancellations as stipulated in the financial policy.

Child's name:_____ Date of birth: _____

X_____ _____ _____

(Signature of Parent/Guardian) (Date) (Printed Name)

HIPPA 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.

This Notice of Private Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of PHI

Your PHI may be used and disclosed by your physician our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a home health agency that provides care with you. For example, your PHI may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for therapy services that may require that your relevant PHI be disclosed to obtain approval for the approved therapy services.

Healthcare Operation: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training or medical students, licensing and conducting or arranging for the other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use sing-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: As required by law, Public Health Issues as required by law, Communicable Disease, Health oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement , Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity and National Security, Workers Compensation, Inmates, Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164,500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke the authorization at any time in writing, except to the extent that your physician or the Physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

You have the right to request a restriction of your PHI: This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to a family member or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices, your request must state the specific restriction requested and to whom you want the restriction to apply.

Food Authorization Form

Child's Name:_____ DOB/Age:_____

List ALL known food allergies: _____

_____

_____

_____

We are not a peanut, tree nut or allergen-free clinic. We do try to take precautions to ensure that your child does not ingest one of their known allergens. To best accommodate their needs, please provide a list of items they can and cannot eat.

Please list any food items they cannot ingest: _____

_____

_____

_____

_____

☐ I **authorize** Compass BDC to provide food/snack items.

☐ I **do NOT authorize** Compass BDC to provide food/snack items.

X_____ _____ _____

(Signature of Parent/Guardian) (Date) (Printed Name)

_____

(Preferred Number)

Diaper/Bathroom Assistance Authorization Form

Child's Name:_____ DOB/Age:_____

I authorize Compass staff to:
- ☐ Change diaper/pull-ups
- ☐ Apply ointment
- ☐ Assist with bathroom training/wiping
- ☐ Changing clothes

Apply ointment topically:
- ☐ When rash is present
- ☐ With every diaper change
- ☐ Other: _____

Allergies to Latex: ☐ Yes ☐ No

Diaper/Pull-up Brand Provided:_____

Ointment Brand Provided:_____

Further Instructions:_____

_____

_____

_____

☐ I **authorize** Compass BDC staff to change my child's diaper/take them to the bathroom, while in the clinic receiving treatment. I agree to supply an extra change of clothes, wipes, diapers, ointments, and any other supplies needed. I understand it is my responsibility to make Compass staff aware of any allergies or sensitivities related to diapers, ointments, or anything else of that nature. Compass will contact you if you we out of diapers. Staff will use gloves during the diaper change.

☐ I **do NOT authorize** Compass BDC staff to change my child's diaper/take them to the bathroom.

X_____ _____ _____

(Signature of Parent/Guardian) (Date) (Printed Name)

_____

(Preferred Number)