Enrollment With Therapy Forms

Dear Parents,

To initiate therapy services all required AFAA/HPC enrollment forms must be submitted before services can start:

- **Previous evaluations**
- **Most recent progress note**
- **Treatment goals (e.g., IFSP, IEP, treatment plan)**
- **Doctor prescription**
- **For ABA Therapy we need an autism diagnostic report/proof of diagnosis from neurologist or physician.**

Therapists begin with doing either a formal evaluation or informal assessment to evaluate treatment goals and make recommendations for service minutes needed. A therapist is able to carryover current treatment goals and minutes of service from a provider.

Signing the release of information form, the permission form and the health form will allow our staff to collect the required information if preferable.

Thank you and Welcome to the AFA Academy/Howard Park Center

AFA Academy/Howard Park Center

Intake and Enrollment Information

Date:_____

Please complete this form and return it to the Academy. This information is necessary to comply with state licensure regulations as well as assist our staff in getting to better know your child.

BACKGROUND INFORMATION

Child's Name:_____ Birth date: _____

Address: _____

Chronological Age: _____ Sex: _____ SSN: _____

Mother's Name: _____

Address: _____

_____

Home Telephone: _____

Employer: _____

Work phone: _____

Hours (days) of work: _____

Email (mandatory): _____

Cell phone (mandatory): _____

Father's Name: _____

Address: _____

_____

Home Telephone: _____

Employer: _____

Work Phone: _____

Hours (days) of work: _____

Email (mandatory): _____

Cell phone (mandatory): _____

EMERGENCY CONTACTS: (other than parents or doctor)

Name:_____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Persons authorized to take your child from the Academy.

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Who referred you to AFAA/Howard Park Center? _____

1. The AFA Academy/HPC has a PTO parent representative. It is common practice for the parent representative to contact and welcome all new Academy families.

YES, I want to be contacted.

Signature _____

NO, I do not wish to be contacted

Signature _____

2. YES, I grant permission to AFAA/HPC, or persons authorized by it, to photograph my child _____ to use such photographs for public relations and operational purposes.

Signature _____

NO, I do not grant permission for AFAA/HPC or persons authorized, to photograph my child.

Signature _____

3. Each year we prepare a parent directory which includes the name, address, and telephone number of the parents of each child.

YES, I want to be listed.

Signature _____

NO, I do not wish to be listed.

Signature _____

Please read the following statements and sign below:

I hereby release AFAA/HPC and those persons operating in its duly authorized behalf, from any responsibility for injury, illness, or accident of my child, considering as long as due care is taken.

I hereby exonerate AFAA/HPC from any damages the child may cause to any person or property while he/she is in the care of the Center.

I understand that my child may be released at any time during the program by the director if in the director's judgment, the child is not making satisfactory progress or, if it is determined that the child has hampered the safety, welfare, health, of other children or staff.

I have received and reviewed the enclosed Parent Handbook containing HPC policies including: program descriptions, mission statement, control and discipline, human rights, grievance procedures, discharge and transfer, and health pertaining to my child's enrollment at AFAA/HPC.

Upon admission of my child _____to AFAA/HPC I hereby give consent to person duly authorized to act on its behalf, the unqualified right and permission to use their discretion in obtaining emergency medical and hospital care at my expense. In the event that I cannot be reached, the Center may arrange for a physician/hospital to secure proper treatment, order treatment, order injection, anesthesia, or surgery for my child.

Signature _____

Please attach a recent picture of your child. It is **MANDATED** by the state that every child's file contain a photo. Thank you.

Child's name: _____ Date: _____

Please use the remainder of this page to write a short biography of your child. Include things you enjoy doing together, personality, goals you would like him/her to accomplish, areas of concern, or anything else you feel comfortable in sharing.

Introducing: _____

RELEASE OF INFORMATION FORM

I authorize the release of any and all reports and evaluations, as well as verbal communications regarding my child to **Howard Park Center, 15834 Clayton Road, Ellisville, MO 63011, (636) 227-2339, (636) 227-8711 (fax).**

Student: _____ DOB: _____

Parent's Signature: _____ Date: _____

Pediatrician/Doctor: _____

Address: _____

Phone: _____ Fax: _____

School District Personnel: _____

Address: _____

Phone: _____ Fax: _____

Case Manager: _____

Address: _____

Phone: _____ Fax: _____

Specialist/Doctor (i.e. Neurologist): _____

Address: _____

Phone: _____ Fax: _____

Private Speech Therapist: _____

Address: _____

Phone: _____ Fax: _____

Private OT: _____

Address: _____

Phone: _____ Fax: _____

Private PT: _____

Address: _____

Phone: _____ Fax: _____

PRIVATE BCBA: _____

Address: _____

Phone: _____ Fax: _____

If you need more room please write on the back or include another sheet of paper. (Cardiologist, Urologist, Nutritionist etc.)

AFA Academy/Howard Park Center
15834 CLAYTON ROAD * ELLISVILLE, MISSOURI 63011* 636-227-2339
FAX 636-227-8711

Date:

Re:

Dear Dr.

I am pleased that AFAA/Howard Park Center can offer pediatric therapies to your patient.

AFAA/Howard Park Center is a private non-profit facility designed to meet the needs of infants and preschoolers with mild, moderate or severe mental and/or physical developmental problems and to provide support to their families. We are licensed by the Department of Mental Health and are a vendor for Medicaid. In order for your patient to receive services at our Center, I must have a referral from you. Please complete the attached prescription form and return it to me.

If you have any questions regarding this referral, please contact me at (636) 227-2339. Thank you for your cooperation.

Sincerely,

Kathy Gagnepain
Principal

RELEASE

Permission granted to send a referral/prescription form to the physician named below:

_____

I understand that there must be a physician's referral form signed prior to my child receiving therapy services at AFAA/Howard Park Center.

_____
Child's Name

_____
Parent's Signature

_____
Date

AFA Academy/Howard Park Center
15834 CLAYTON ROAD * ELLISVILLE, MISSOURI 63011* 636-227-2339
FAX 636-227-8711

PRESCRIPTON FORM FOR THERAPY

Date: _____

Child's Name: _____

DOB: _____

RX: _____

Please check the recommended services:

_____ Physical Therapy (including Aqua Therapy) _____ minutes per week

_____ Occupational Therapy (including Aqua Therapy) _____ minutes per week

_____ Speech/Language Therapy _____ minutes per week

_____ ABA (Applied Behavior Analysis) as medically necessary 28 hours per week

Physician's Signature: _____

Date: _____

PLEASE NOTE: PRESCRIPTIONS ARE VALID
FOR 12 MONTHS FROM THE ABOVE DATE.

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AFA Academy/Howard Park Center

15834 Clayton Road * Ellisville, Missouri, 63011
636-227-2339 * FAX 636-227-8711

I authorize AFAA/Howard Park Center to contact my child's doctors regarding medical information.

Parent or Guardian (please print): _____

Signature: _____ Date: _____

Doctor's Name: _____ Fax #: _____

This form must be completed in its entirety prior to child receiving services from AFAA/Howard Park Center staff and/or before entering our program. We can fax this form to your doctor if you fill out the above information.

DATE OF EXAMINATION: _____

GENERAL INFORMATION

Child's Name: _____ Sex: _____ DOB: _____

Address: _____

Height: _____ Weight: _____

Disability (if any): _____

Etiology of disability: _____

SENSES/CONCERNS

Vision Right _____ Left _____ Glasses: ☐ Yes ☐ No

Hearing Right _____ Left _____ Aid: ☐ Yes ☐ No

Tactile: ☐ Yes ☐ No If yes, explain: _____

Olfactory: ☐ Yes ☐ No If yes, explain: _____

Gustatory: ☐ Yes ☐ No If yes, explain: _____

Please list any health concerns/ limitations and any special instructions that our staff needs to be aware of:

Health concerns/Limitations	Special Instructions

ALLERGIES

Please list all allergies and reactions/treatment

Allergy	Reaction/Treatment

MEDICATIONS: PLEASE ATTACH A PRESCRIPTION FOR ANY MEDICATION, OVER THE COUNTER OR PRESCRIPTION THAT IS TO BE ADMINISTERED AT SCHOOL. IF WE DO NOT HAVE A SCRIPT, WE ARE NOT ALLOWED TO ADMINISTER ANY MEDICATION.

PLEASE ATTACH A COPY OF CHILD'S IMMUNIZATION RECORD.

GENERAL CONCERNS

In my professional opinion, this child is free from contagious disease. ☐ Yes ☐ No

Any congenital virus? ☐ Yes ☐ No

If yes, what Virus? (Cytomegalovirus, Herpes, etc) _____

Contagious? ☐ Yes ☐ No

Precautions needed due to virus. _____

List any physical limitations of the child or activities he/she is NOT recommended to participate in, i.e., swimming, etc. _____

List any concerns you may have regarding the handling or programming of this child (NOTE: This is extremely beneficial to our center). _____

_____

Physician's Signature * _____

Phone Number _____

* **Please no stamps, signature required.**

Please return this form to:
AFA Academy/Howard Park Center, 15834 Clayton Road, Ellisville, MO 63011
or fax to **636-227-8711.**

AFA ACADEMY/HOWARD PARK CENTER

Directions: This form is used to understand history and concerns of the client and his/her family and is a part of the requirements for some insurance companies. Please complete the intake form to the best of your ability. If there is an item you do not know you can seem relevant to young children however give your best answer. Thank you for your time!

DATE: _____

PATIENT INFORMATION:

LEARNER: _____ DOB: _____

GUARDIAN: _____ PHONE: _____

ADDRESS: _____

Reason for Admission: _____

Primary Physician: _____ Phone: _____

Diagnosis and Codes: _____

I have submitted the results of the evaluation for the diagnosis of autism: ☐ YES ☐ NO

I have a Doctor's Script for ABA services: ☐ YES ☐ NO

Diagnosis by: _____ Date: _____ ICD-9: _____

Other Agencies Involved: _____

FAMILY INVOLVEMENT & SUPPORT (e.g., home life, community services/supports)

Briefly describe what life at home is like (lives with….daily schedule, etc.): _____

_____

_____

Major Life Changes: _____

_____

Family has current Support and Training From: _____

Any Barriers to Generalization of Strategies to Home: _____

_____

COORDINATED CARE

Community services family has accessed and have available: _____

_____

Needed Resources: _____

Need for Discharge & Transition Planning: Discharge: ☐ Yes ☐ No Transition: ☐ Yes ☐ No

RISK ASSESSMENT (client and/or family members – please note who)

Risk/History of neglect: ☐ Yes ☐ No If yes please describe: _____

Risk/History of abuse: ☐ Yes ☐ No If yes please describe: _____

Risk of suicide: ☐ Yes ☐ No If yes please describe: _____

Risk of homicide: ☐ Yes ☐ No If yes please describe: _____

Risk of substance abuse (alcohol, nicotine, illicit drugs) patient/family: ☐ Yes ☐ No If yes please describe: _____

_____

Risk of sexual concerns: ☐ Yes ☐ No If yes please describe: _____

Risk to self/others: ☐ Yes ☐ No If yes please describe: _____

MEDICAL HISTORY

HISTORY: _____

_____

_____

Any concerns with client or family medical history? ☐ Yes ☐ No If yes please describe: _____

Dates previous/current MEDICAL interventions: _____

Test - Lab results: _____

Location/Provider: _____

Treatment/Response: _____

Drug allergies/food allergies/adverse reaction: _____

Medications	Dose	Frequency	Indication	Compliance

DEVELOPMENTAL AND PHYSICAL HISTORY (progress of clients developmental stages, gross motor/fine motor skills)

Prenatal/Perinatal history or events: _____

Developmental history/concerns: _____

Dates previous/current DEVELOPMENTAL interventions or testing (dev therapy, OT, PT, ABA-vbmapp/ablls):

Location/Provider: _____

Treatment/Response: _____

Communication/Collaboration w/providers: _____

GROSS MOTOR SKILLS

AGE AT WHICH:

_____ sat up w/o support _____crawl _____walk _____made first 5 words _____Communicate 5 two-word phrases

CURRENTLY can:

☐ walk/run and walk up steps (w or w/o asst) ☐ walks around objects on floor ☐ protects self with hands when falling
☐ get on and off things (chairs, ride-ons, couch, bed, car seat) ☐ uses playground materials

FINE MOTOR SKILLS

CURRENT SKILLS (check all that apply):

☐ Play with cause and effect toys, push many buttons ☐ Cleans up
☐ Roll ball back and forth to others 3 x ☐ snip/cut
☐ IN; sorter, pegs, puzzle pieces ☐ ON: Ring sorter, stack blocks, duplos/legos
☐ Watches you and imitates you in play ☐ PUSH/PULL: play-doh, push/pull toys, pop beads, string beads
☐ Takes turns, plays together taking turns with others ☐ Pretend play toward self; pretend to eat, dress up clothes on, answers pretend phone
☐ Scribble/draw/copy lines/shapes ☐ Plays with objects as intended/function/stays with play for long time
☐ tolerate messy play and various tactile mediums

SOCIAL HISTORY (e.g.; clients eye contact, interaction with others, communication with others)

History: _____

Dates previous/current SOCIAL interventions and testing (ADOS): _____

Location/Provider: _____

Treatment and Responses: _____

_____

Communication/collaboration with providers: _____

_____

CURRENT SKILLS (check all that apply):

- ☐ Make regular eye contact with adults
- ☐ Makes regular eye contact with peers
- ☐ stays in a silly game for 2 minutes
- ☐ Enjoys affection (hugs, kisses)
- ☐ Looks when name is called
- ☐ Turns eyes toward loud noises
- ☐ Follows simple directions
- ☐ Enjoys playing silly games together (e.g.; peek-a-boo)
- ☐ Participates in 10 silly games
- ☐ Makes eye contact w/pointing when wants/to ask for something
- ☐ Makes eye contact w/pointing to show you/non verbally label things and share enjoyment
- ☐ Shifts eye contact between you and an object frequently to show and share enjoyment
- ☐ When named points to/gets items
- ☐ Vocally labels items
- ☐ Vocally fills in words to songs/books

COMMUNICATES FOR ITEMS BY: ☐ scream/cry to get ☐ pull you to it ☐ gestures-points to it ☐ picture/signs ☐ says word to get

COMMUNICATES FOR HELP/OPEN BY: ☐ scream/cry to get it ☐ gestures-offer it to you ☐ sign ☐ say word to get help-open

COMMUNICATES TO PROTEST: ☐ scream/cry ☐ gestures-shakes head no ☐ picture or sign ☐ says no

COMMUNICATES FOR BREAK/END: ☐ scream/cry ☐ picture or sign ☐ says "done, all done, break"

COMMUNICATES FOR YOUR ATTENTION: ☐ scream/cry ☐ gesture-wave, grab you, gets in your lap, gets in front of your ☐ picture/sign ☐ says hi, mama, dada, hug, kiss, cuddle

COGNITIVE/ACADEMIC/EDUCATIONAL-SCHOOL HISTORY (clients)

History: _____

_____

_____

_____

Mental Status: please list any concerns with clients affect, speech, mood, thought content, judgment, insight, attention, concentration, memory, impulse control: _____

_____

_____

Dates previous/current EDUCATIONAL interventions or testing (mullen/bailey/wisc): _____

Location/Provider: _____

Treatment/response: _____

_____

_____

Communication/collaboration w/providers: _____

_____

CURRENT SKILLS (check all that apply)

- ☐ Match identical items (e.g., when playing grabs two of the same apples)
- ☐ Matches identical pictures (e.g., can match dog piece to dog in a puzzle), match pics to a book
- ☐ Matches by color (e.g., accurate with colored circles to correct color on a sorter)
- ☐ Selects when named or vocally labels 8 of each colors/shapes
- ☐ Selects when named or vocally labels letters/numbers

ADAPTIVE BEHAVIOR HISTORY (clients daily living skills-dressing, eating, hygiene/grooming, chores)

History: _____

_____

_____

Dates previous/current interventions or testing (e.g., vineland II, adaptive behavior scale): _____

Location/provider: _____

Treatment & Response: _____

Communication/collaboration w/providers: _____

CURRENT SKILLS (check all that apply):

TOILETING:

☐ takes diaper off	☐ when cued to go potty locates toilet	☐ push down pants
☐ urinates in toilet	☐ has bowel movement in toilet	☐ wipes
☐ pull up pants	☐ flushes	☐ goes to sink
☐ turns on water	☐ gets soap	☐ rubs hands
☐ rinses hands	☐ turns off water	☐ gets paper towel
☐ dries hands	☐ throws towel away	

DRESSING (ON):

☐ None ☐ Shoes ☐ socks ☐ pants ☐ shirt ☐ coat ☐ diaper/underwear ☐ snap ☐ zip ☐ button ☐ tie

DRESSING (OFF)

☐ none ☐ shoes ☐ socks ☐ pants ☐ shirt ☐ coat ☐ diaper/underwear ☐ unsnap ☐ unzip ☐ unbutton ☐ untie

HYGIENE/GROOMING

☐ none	☐ wash face	☐ wash hands	☐ wash hair	☐ wash other parts
☐ brushes hair	☐ wipes nose	☐ wipes face/hands	☐ tissue in trash	

WHEN CUED TO BRUSH TEETH:

☐ gets toothbrush	☐ gets toothpaste	☐ puts paste on brush	☐ brushes for 10 seconds
☐ brushes 1 minute	☐ rinses/spits	☐ rinse brush	☐ put items away

FEEDING:

☐ finger feeds	☐ uses a spoon with prompts	☐ uses a fork with prompts	
☐ uses a spoon	☐ uses a fork	☐ drinks from a bottle	
☐ drinks from a sippy cup	☐ drinks from a an open cup	☐ drinks from a straw	
☐ cut food	☐ sits and stays at table for meal	☐ sits in booster seat	
☐ highchair	☐ chair	☐ on your lap	☐ my child does not sit to eat

EATING:

LIKES FOOD: ☐ frozen ☐ cold ☐ cool ☐ hot ☐ warm ☐ room temperature

LIKES FOOD TEXTURE TO BE: ☐ melt-able ☐ crunchy ☐ strained ☐ pureed-baby food ☐ lumpy ☐ fork mashed ☐ finger food ☐ table foods

EATS:

☐ raw fruits	☐ raw vegetables	☐ cooked vegetables	☐ crunchy
☐ grain	☐ snack	☐ meats	☐ milk
☐ juice	☐ water	☐ cheese	☐ yogurt
☐ food combination (soup/casseroles)			

BEHAVIORAL/ PSYCHIATRIC / PSYCHOLOGICAL / EMOTIONAL HISTORY (client and/or family - please note who)

HISTORY: _____

Dates previous/current interventions or testing (child behavior checklist, BASC): _____

Location/provider: _____

Treatment & Response: _____

Communication/collaboration w/providers: _____

CURRENT INAPPROPRIATE BEHAVIORS: please check & write on the line how many times per WEEK it occurs (e.g., 5, 5-10, 10-20, too much to count)

_____ Inappropriate verbal behavior such as loud vocalizations and/or inappropriate vocalizations or statements, (e.g., swearing, threat of harm statements, screaming, protesting, statements of negativity, foul language)

_____ Eloping/escaping- any attempt or success at leaving seat/ situation by butt off chair or walking/ running in other direction, when not directed. May or may not include dropping to the ground in which child's bottom or knees contacts the ground. Running away

_____ Aggression OR Property disturbance (PD)- any attempt or success at hitting, kicking, punching, biting, scratching, pinching, pulling hair, spitting, ripping/tearing, throwing, directed at others or materials/property.

_____ Self-Injury- (SIB) any attempt or success at hitting, punching, biting, scratching, pulling hair, pinching/picking/poking, directed at self. Results in injury to client (bruises, scratches, hair loss, blood, wounds)

_____ Pica- putting inedible and/or non-food items past plane of lips and in mouth and/or ingesting these items.

_____ Fear responses- difficulty tolerating unpleasant / undesired stimuli often including one or many of the abovementioned target behaviors (e.g., loud vocalizations/protests and escape behavior in the presence of loud noises, touch/tactile sensations, places/activities- mall/doctor-exam or shot/ dentist- cleaning/barber-haircut.

_____ Non- compliance and/or non-responding (failing to respond within 10 seconds of a direction). May include vocal protesting

_____ Food refusal/selectivity- refusing to eat certain foods (via verbal protest/ motor protests such as hit utensil/spit food out of mouth beyond plane of lips).

_____ Stereotypic motor movements Any time the learner engages in a "off task" behavior more than 2 times within the period of 2 minutes. May include a repetitive motor movement that does not pertain to the on-going activity/out of context. (e.g., spin objects, flap hands/strings/toys, hand-to -head/mouth, flick hands against items, etc.) or Rigid PATTERNS of behavior or routines of preferred interaction with the environment that when blocked triggers problem behaviors (e.g., repetitive opening/closing, straightening things, doing things in a certain order, not tolerate adult control of preferred items

_____ Other unsafe behavior or inappropriate behavior: _____

_____

_____

PRESENTING CONCERNS

SPEECH/LANGUAGE/COMMUNICATION: _____

_____

_____

SOCIAL: _____

_____

_____

SENSORY: _____

_____

_____

COGNITIVE: _____

_____

_____

HEALTH/PHYSICAL/BEHAVIOR/MEDICALLY STABILITY: _____

_____

_____

ADAPTIVE FUNCTIONING WHEN COMPARED TO DEVELOPMENTALLY EXPECTED FUNCTIONING: _____

_____

_____

ASSESSMENT

Although HPC offers assessment for Applied Behavior Analysis, Occupational therapy, Physical Therapy, and Speech Language Therapy, Assessments of vocational skills and intervention, chemical dependency, legal needs, spiritual and cultural needs are currently not offered

Please list any spiritual needs or issues that may impact delivery of services or treatment. _____

_____

_____

Please list any cultural needs or issues that may impact delivery of services or treatment. _____

_____

_____

Please list any legal or chemical dependency needs or issues that may impact delivery of services or treatment. _____

_____

_____

Level of current treatment services & expected completion date is: _____

_____

Thank you again for your time!!!!!
Sincerely,
AFAA/HPC Team

Insurance Information: Mandatory

It is AFAA/HPC's policy that we will bill a family's private insurance policy for the services given to their child but only after a parent has given us permission to do so.

Please initial here to give AFAA/HPC permission to bill your insurance company. _____

Please initial here to give AFAA/HPC permission to bill you the parent pay rate for OT, PT, ST at $75.00 per session, with a session maximum of 1 hour, in lieu of billing. ABA Para rate will be billed at $45 per hour, ABA Lead at $75 per hour and Board Certified Behavior Analyst will be billed at $100 per hour. _____

It is also AFAA/HPC's policy to make a claim to the insurance company the month after the services were rendered. If a claim is rejected for any reason, AFAA/HPC staff will comply with the requests from the insurance company and resubmit the claim. If after the second attempt, the claim is rejected, no further claims will be submitted to the insurance company and parents will then be responsible for the services rendered. Please note, OT,PT and ST are a separate service from ABA, and will be billed separately should a family wish to have those therapy services.

Learner's therapy slot can be held for 2 weeks pending appeals. If at that point insurance has not authorized services, the learner will be put on the wait list until service is authorized.

Please sign here that you have read and understand this policy. _____

Parent/Guardian signature

We request a copy of all insurance cards (front and back) as well as Medicaid, if applicable. In addition, please complete:

Primary insurance:

Company name: _____

Company address: _____

Company phone: _____

Policy holder's full name: _____

Policy holder's date of birth: _____

Child's name: _____

Child's date of birth: _____

Policy number: _____

Group number:_____

Secondary insurance:

Company name: _____

Company address: _____

Company phone: _____

Policy holder's full name: _____

Policy holder's date of birth: _____

Child's name: _____

Child's date of birth: _____

Policy number: _____

Group number: _____

Medicaid:

Name on card: _____

State issued: _____

Medicaid number: _____

Medicaid phone: _____

Notice of Privacy Practices

I have read the attached Notice of Privacy Practices brochure.
I authorize the AFAA/Howard Park Center to use
and disclose my child's personal medical information as outlined.

_____

Print Child's Name

_____

Parent's Signature

_____

Date

(I have kept the attached copy of AFAA/HPC Privacy Practice for my personal files.)

Notice of Privacy Practices (KEEP FOR YOUR RECORDS)

This Notice describes how medical information about your child may be used and disclosed and how you can get access to this information. Please review carefully.

This Notice is intended to inform you about our practices related to your child's medical records. It will explain how AFAA/HPC may use and disclose medical information, our obligations related to the use and disclosure of medical information, and your rights related to any medical information that we have about your child.

We have listed some of the reasons why we might use or disclose medical information, with some examples. Not every potential use or disclosure is discussed, but all of the ways that we are allowed to use and disclose information falls into one of the categories below.

Use & Disclosure of Medical Information:

For Treatment: To provide your child with medical treatment or services, we may need to use or disclose information about your child to personnel involved in the treatment. For example, a therapist may need to consult with another therapist regarding your child's condition while providing care.

For Payment: We may use and disclose your child's medical information to bill and receive payment for the treatment received. For example, we may use or disclose medical information to your insurance company about a service received from AFAA/HPC so that your insurance company can pay us or reimburse you for the service.

For Health Care Operations: We can use and disclose medical information about your child for our operations. For example, we may use or disclose medical information to evaluate our staff's performance in caring for your child.

Uses & Disclosure of Medical Information that Do Not Require Your Authorization:

We can use or disclose health information about your child without your authorization when there is an emergency, or when we are required by law to use or disclose certain information. We may use or disclose health information without your authorization in any of the following circumstances:

- When it is required by federal, state or other law;
- When it is needed for public health activities;
- When reporting information about victims of abuse, neglect or domestic violence;
- When disclosing information for the purpose of health oversight activities;
- When disclosing information for judicial and administrative proceedings;
- When disclosing information for law enforcement purposes;
- When we believe in good faith that the disclosure is necessary to avert a serious health or safety threat;
- When disclosure is necessary for specialized government functions;
- When disclosing is necessary to comply with worker's compensation laws or purposes.

Planned Uses or Disclosures

We may use or disclose your health information for any of the purposes described in this section unless you affirmatively object to or otherwise restrict a particular release. You may direct your objections or restrictions in writing to the Director of AFAA/HPC.

- We may use or disclose your health information to contact you and remind you about any appointment for treatment.
- We may use or disclose your health information to provide you with information about or recommendations of possible treatment options or alternatives that may interest you.
- We may use demographic information about you including your name, address, and phone number to contact you and to seek private support for the Howard Park Center. If you do not wish for your information to be used for such purposes, please contact the Director.
- We may not release health information to a friend and/or family member who is involved in your child's care. We cannot tell your family and/or friend that you are using HPC for treatment or services. We can not give this information to someone who will help or is helping to pay for your care.
- We cannot disclose health information to a public or private entity that is authorized by law or its charter to assist in disaster relief efforts (e.g., the American Red Cross).

Other Uses or Disclosures

If you provide us written authorization to use or disclose your health information, you can change your mind and revoke your authorization at any time in writing. If you revoke your authorization, we will no longer use or disclose the information, but we will not be able to take back any disclosures that we have already made.

Your Rights with Respect to Health Information

- Right to inspect and copy your health information. You have the right to inspect and copy your health information, with certain exceptions. If you request copies of information, we may charge a fee for costs associated with your request, including the cost of copies, mailing or other supplies.
- Right to request information in certain form and location. You have the right to request health information in a certain form or at a specific location. For instance, you can request that we not contact you at work. The request must tell us how and/or where you want to receive information. We will accommodate reasonable requests.
- Right to request amendment to health information. You have a right to request that your child's health information be amended if you believe that it is incorrect or incomplete. You must provide the reason that you want the amendment added to the health information. Your request must be in writing.
- Right to an accounting of disclosures. You have the right to receive any accounting of disclosures of medical information that we have made, with some exceptions. You have the right to receive one (1) free accounting every twelve (12) month period; we may charge a reasonable fee for the costs of providing that list.
- Right to request restrictions. You have the right to request that we restrict any use or disclosure of health information. If we agree to your restriction, we will comply with your request. For example, a patient who does not want his physician to share health information with other physicians involved in his care may request to restrict such disclosure. We are not required to accept any restriction that you request.

Federal law gives all patients a right to a paper copy of this Notice. If you have agreed to receive this Notice in another form, you can still request a paper copy of this Notice.

Privacy Complaints

If you have any questions about the consent of this Notice, or if you need to contact someone regarding the privacy of your health information, please contact the Director of AFAA/HPC.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint with either HPC or the U.S. Department of Health and Human Services.

Changes to this Notice

We reserve the right to change or modify the information contained in this Notice. Any changes that we make will comply with appropriate federal, state or other laws. AFAA/HPC will provide its patients with the most recent copy of this Notice and post this version at our facility.