Abilities First Pediatric Therapies/Autism Learning Center Case History *Date___/___/___*

Identifying Information:

Child's Name:

_____

Last First Middle

Sex: ____Male ____Female Name child prefers: _____Birthdate: ___/___/___

Diagnoses: _____ __

With whom does your child live? _____ __

Relationship to child: _____

Name of legal guardian:_____

Sibling Information:

Name: _____ Age: _____ Do they live in same household? _____

Name: _____ Age: _____ Do they live in same household? _____

Name: _____ Age: _____ Do they live in same household? _____

Name: _____Age: _____ Do they live in same household? _____

School Information:

In what school district do you live? _____

If attending school/pre-school/day care: What is the name of the school? _____

Does your child have an IFSP/IEP or service plan? ___Yes ____No

Birth History:

Length of Pregnancy _____ Birth Weight: _____

Type of Delivery: ____Vaginal _____C-Section

Complications before/during/after delivery_: _____

_____

_____

Child's Developmental History:

How was your child fed as an infant? ____Breast ____Bottle ____G-tube

When were baby foods added? _____ When were table foods added? _____

Was there normal weight gain? ____ Yes ___ No Does your child eat well? _____ Yes ____ No

Were there any problems such as vomiting, diarrhea, constipation or colic? ___Yes ____No

If yes, please indicate which one(s): _____

Nutrition: Describe briefly typical breakfast/lunch/dinner: (if a concern) _____ __

_____

_____

Give the age, or approximate age at which your child did the following:

Motor	Age		Motor	Age
Lifted head when on stomach			Walked alone	
Balanced head when propped on elbows			Climbed steps	
Rolled over (stomach to back)			Ran	
Rolled over (back to stomach)			Rode tricycle	
Sat with support			**Language**	**Age**
Sat alone			Babbled	
Crawled			Said single words	
Stood with support			Could be understood	
Stood alone			Said 3-word sentences	

Self Help	Age		Self Help	Age
Drank from cup			Ate with assistance	
Feed Self Finger Foods			Toilet trained: bladder	
Feed self with spoon			bowel	

Recent Medical History:

List all medications your child is currently taking:

Medication/Supplement- Purpose	Medication/Supplement - Purpose

List all hospitalizations, chronic illnesses, serious injuries which may have been associated with your child's difficulties:

AGE	Reason

Child has or has had seizures. ____Yes ____NO
Child has allergies to the following: _____
Child's immunizations are up to date? ____Yes ____No If no, give reason: _____
Child has previously received therapy? ____Yes ____No ____PT ____OT ____ST
Child received a vision test? ____Yes ____No When/Where? _____
Results: _____
Child has received hearing test? ____Yes ____No When/Where? _____
Results: ____Normal or Hearing Loss: ____Mild ____Moderate ____Severe
Child has frequent ear infections? ____Yes ____No
Child has or had PE tubes? ____Yes ____No If yes, when were they inserted? _____

Current physicians involved in your child's care:

List all of child's physicians (i.e. Orthopedic, Neurologist}

Doctor	Specialty	Date last seen

Habits and Personality:

What does your child like to do?_____

_____

How does your child express unhappiness, anger, frustration? _____

_____

Sleep patterns: How long? _____ Where does your child sleep? _____

Parent Concerns/Expectations:

_____

_____

_____

_____

If you need more space - Please write on back of second page

Emergency Information

Child's Name: _____ Parent/Guardian: _____

Street: _____ Work Phone: _____

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

Home Phone: _____ Work Phone: _____

Part 1

Please list an emergency contact other than parent/guardian:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Preferred Hospital: _____

Preferred Doctor: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Part 2

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

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

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

Parent/Guardian Signature: _____ *Date___/___/___*

Part 3

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

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

_____

_____

Parent/Guardian Signature: _____ *Date___/___/___*

Abilities First Pediatric Therapies/Autism Learning Center

Authorization to Pick up Child

Child's name: _____Date of Birth___/___/___

The following individuals are authorized to pick up the above named child.

Name	Relationship to Child	Phone	Alternate Phone	Date added or deleted
	Parent or Guardian			

Please sign on the first line below:

Parent/Guardian	Relationship to Child	Date
Parent/Guardian	Relationship to Child	Date
Parent/Guardian	Relationship to Child	Date
Parent/Guardian	Relationship to Child	Date
Parent/Guardian	Relationship to Child	Date
Parent/Guardian	Relationship to Child	Date
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Parent/Guardian	Relationship to Child	Date
Parent/Guardian	Relationship to Child	Date
Parent/Guardian	Relationship to Child	Date

Abilities First Autism Learning Center

SIGNATURE PAGE

Client: _____

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

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

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

_____Family Rights and Responsibilities Code of Ethics

_____Attendance Policy

_____Notice of Privacy Practices (HIPAA)

_____ ____/_____/_____
Signature Date

_____ ____/_____/_____
AF Employee Signature Date

Abilities First Pediatric Therapies/Autism Learning Center

Consent Form

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

Consent for Treatment:

_____Agree _____Disagree

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

Consent for Observation:

_____Agree _____Disagree

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

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

_____Agree _____Disagree

_____
Parent/Guardian

_____
Date

Acknowledgement of Receipt cif HIPAA Notice of Privacy Practices

ABILITIES FIRST

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES

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

_____

Patient/Student Name (Please Print)

_____ _____

Patient/Student Signature Date

OR

_____

Signature of Personal Representative

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

[ ]Parent [ ]Guardian [ ] Power of Attorney [ ]Other:_____

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

_____

Office Use Only

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

____An emergency prevented us from obtaining acknowledgement.

____A communication barrier prevented us from obtaining acknowledgement.

____The individual was unwilling to sign.

_____Other: _____

_____ _____

Staff Member Signature Date

Abilities First Pediatric Therapies/Autism Learning Center
GENERAL INFORMATION

Date: .....

Child's Name: _____
Last First Middle

Male_____ Female____

Child's Social Security# _____Birthdate: _____

Referring Physician: _____

Diagnosis:_____

Parent/Guardian – Mother: _____ Birthdate_____
Parent/Guardian – Father: _____ Birthdate_____

Address: _____

City: _____State: ____ Zip code: _____County _____

Home Phone: _____ Cell Phone: _____
Work Phone: _____ Cell Phone: _____

E-mail address: _____

If different from Parent/Guardian:
Birth Mother's Name: _____ Birthdate: _____

Birth Father's Name: _____ Birthdate: _____

Race:
___White/Caucasian ___Black/African American ___Asian ____Multi-Racial
___Native Hawaii/Pacific Islander ____American Indian/Alaskan Native ____Other

Ethnicity: ____Hispanic ____Non-Hispanic

Household Income:
___$0-$9,999 ___$10,000-$14,999 ___$15,000-$24,999
___$25,000-$34,999 ___$35,000 & Above ___Unknown

Autism Learning Center
Attendance Policy

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

Where does drop off and pick up occur?

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

Drop-off** occurs no earlier than 5 minutes prior to 9:00am. *If you arrive after 9:30am, wait in the lobby and a staff member will walk your child to their assigned classroom.*
***This is to limit disruption, as activities have already begun.*
******At 10:00am, your child has been marked absent and you need to call first before arriving tardy.***

***Pick-up** occurs no earlier than 5 minutes prior, to 10 minutes after, the end of your child's class time:
- Preschool: 2:00pm – 2:10pm
- Kindergarten – 2nd Grade: 3:00pm – 3:10pm

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

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

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

You are responsible for calling the Director of Autism Learning Center, Sarah Watts, at 513-423-9496 x 413, emailing Sarah.Watts@abilitiesfirst.org, or messaging ALC staff on Procare *within one hour to the start of the school day.*

What is considered an excused or unexcused absence?

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

> **Excused Absence:** An illness, accident or other emergency situation, or a notification within one hour to the start of the school day. The absence will be considered unexcused until a parent/guardian makes direct contact with the Director or Assistant Director to verify the student's absence, or provide written documentation (e.g., doctor's note).
>
> **Unexcused Absence:** Not notifying the ALC staff, not showing up for school, or a non-emergency situation in which a call is received less than 4 hours in advance of the school day.

What happens after twelve (12) for Preschool, fourteen (14), for K/2, excused absences?

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

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

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

What happens after six (6) unexcused absences?

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

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

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

Student Name: _____

Parent/Guardian Signature _____ Date _____

AF Employee witnessed _____ Date _____

Autism Learning Center
CLIENT/FAMILY RJGHTS

- The client/family has the right to considerate and respectful care.
- The client/family has the right to know the name and qualifications of anyone providing his/her care.
- The client/family has the right to expect that all communications and records pe1taining to his/her care will be treated confidentially.
- The client/family has the right to receive information to make inform d consent.
- The client/family has the right to express feeling and opinions and to be listened to, and taken seriously.
- Except in situations of child endangerment, the client/family has the ultimate decision regarding which type of services to use or refuse. Services may not be given without client/family consent.
- The client/family has the right to give input into the IEP and to obtain ongoing information about progress toward goals.
- The client/family in entitled to have full access to info1mation regarding their child. Families may or may not choose to have information shared between agencies.
- The client/family have the right to investigate and pursue solutions for any issues regarding for any issue regarding the client's therapy with the therapists and/or all levels of management within the agency.
- Abilities First does not engage in discrimination of clients or staff based on place of residence, race, creed, color, nation origin, disability, sex, religion, or source of payment.

Autism Learning Center
CLIENT/FAMILY RESPONSIBILITIES

Your responsibilities as a client/family include:

- Providing accurate health care information.
- Pa1ticipating in goal setting with IEP team members.
- Following the prescribed course of care and treatment, including home programming.
- Adhering to the attendance policy, including providing or arranging for transportation and being on time for school.
- Providing the Director of ALC or the Children's Programs Service's Coordinator with all changes regarding the child's general information (i.e. name, address, funding, guardianship, phone number changes, etc.)

6/2022

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

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

Use and Disclosure Of Your Health Information

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

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

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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

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

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

NOTICE OF PRIVACY PRACTICES

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

Rights That You Have

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

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

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

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

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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

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

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

ABILITIES FIRST CODE OF ETHICS

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