young mind center

ACKNOWLEDGMENT OF RECEIPT OF INTAKE PACKET

By signing below, I, _____ acknowledge receipt of the following:
PRINT NAME OF PARENT/GUARDIAN

1. Acknowledgement of Receipt of Intake Packet
2. Informed Consent & Services Agreement
3. Recurring Clinical Services Agreement (if applicable)
4. Intake Questionnaire
5. Payment Agreement for Services
6. Notice of Privacy Practices
7. HIPAA Release of Information
8. Insurance Verification
9. Explanation of Client's Rights & Responsibilities

The **Explanation of Client's Rights & Responsibilities** is yours to keep for future reference.

PARENT/GUARDIAN SIGNAURE DATE

Please complete, sign, and date items 1-8 and return them to the Young Mind Center by email, fax, or postal mail:

Young Mind Center
3202 E. Mountain View Rd.
Phoenix, AZ 85028
office: 602.237.6653
fax: 602.957.3600
email: office@youngmindcenter.org

INFORMED CONSENT & SERVICES AGREEMENT

Welcome to the Young Mind Center. The purpose of this document is to provide written information regarding the expected outcomes, risks, benefits and alternatives to the various services provided by the Young Mind Center. Additionally, this agreement describes Young Mind Center policies, including billing. This information is provided to you in addition to the discussion you have had with Young Mind Center team members. Please read this entire document carefully. You must indicate your understanding of this information by providing your initials where indicated and signature at the end of this form.

About Our Providers

Our providers, which include psychologists, behavior analysts, behavior technicians, and other specialists (herein also referred to as "provider (s)") are governed by various laws and regulations, as well as codes of ethics set forth by their respective boards, including the American Psychological Association and Behavior Analytic Certification Board. These ethics codes require that we explain your rights as a client and our responsibilities as your treatment provider. Please read the following information carefully and write down any questions you might have so you can discuss them with your provider at your next appointment.

Young Mind Center is comprised of professionals with expertise in the fields of school and clinical psychology, behavior analysis, occupational therapy, and speech and language pathology. All providers employed or contracted with Young Mind Center are appropriately credentialed, licensed, and insured in accordance with the requirements of each provider's specific profession.

As an organization committed to the development of experts in the field of neurodevelopmental disorders, Young Mind Center is an approved training sites for both undergraduate and graduate- level interns in the fields of psychology and behavior analysis. Additionally, YMC is an APPIC-accredited training site for post-doctoral psychology residents. Licensed clinicians directly supervise all practicum students, interns, and residents and are ultimately responsible for any services they provide. Clients are always notified in advance if an intern or resident will be involved in their child's treatment and have the right to decline these services. _____ **Initial**

About Our Services

Our services take a variety of forms depending on the needs of the client and the particular issues you would like to address. To address the presenting issues, we use such methods as consultation, psychological assessment, and various therapies. Working with our providers is unlike a visit to a medical doctor; it calls for active participation on the part of the client.

Psychological Assessments

Psychological, psychodiagnostic, and psychoeducational evaluations, are included under this agreement. Unless otherwise indicated, these services are billed at an hourly rate and may include observations, assessment, assessment scoring, teacher/parent interviews, report writing, and meeting attendance. While the risks involved in assessment are less than those of typical psychotherapy, the limits of confidentiality are the same and can be read in the confidentiality section of this agreement.

Independent Educational Evaluation (IEE)

An IEE is an evaluation to determine a student's current level of functioning and how this impacts their academic performance. Typically, these services are paid for directly by a school or school district; however, in some circumstances, a parent may request and privately pay for an IEE and later seek reimbursement from the district. Rates are determined and agreed to by all parties involved prior to the provider rendering services. Often, these fees do not include the provider attending the school/team meeting to interpret the findings and recommendations. However, this service is available and additional charges may apply.

Applied Behavior Analysis (ABA) Services

Applied behavior analysis is a systematic approach to the evaluation of behavior and the implementation of interventions to cause behavior change. For children with autism spectrum disorders, ABA therapy is among the evidence-based best practices in therapeutic and educational interventions. Our goal is to create an individualized therapy plan for each child and family that results in long-lasting positive outcomes. This process may start with a functional behavioral assessment, which is a problem-solving process used to address behaviors and determine their purpose. Intervention techniques are developed based on the assessment to directly address and modify the behavior. Our direct ABA services are provided by Registered Behavior Technicians (RBTs) and overseen by Licensed and Board-Certified Behavior Analysts (LBAs, BCBAs).

Individual Therapy

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you or your child may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. Alternatively, psychotherapy has also been shown to have benefits including better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of the type of feelings or results that you or your child will experience. The first one to two sessions typically involve an evaluation of you or your child's needs. At the end of the evaluation, the provider will be able to offer you some first impressions of what the work will entail and a course of action, if you decide to continue. You should evaluate this information and decide if you feel comfortable working with the provider. The professional relationship is strictly voluntary.

Speech-Language Pathology

Speech-language pathologists (SLPs) address delays in swallowing/feeding, communication, language, speech, and emergent literacy. Because effective communication is fundamental to all human interactions, particularly social interaction and learning, our SLPs play a key role in understanding a child's difficulties to develop and implement a plan designed to optimize their communication skills.

Occupational Therapy

Occupational therapists (OTs) support and promote the development and engagement of children and their families and caregivers in everyday routines, including activities of daily living, education, and play and social interactions. Because daily activities and routines are an important part of a child's learning and development, our OTs play a key role in identifying a child's adaptive challenges to develop and implement strategies designed to support the development of their independent life skills.

Professional Fees

Psychological Services. Our current private pay hourly fee is $200 for in-office appointments and other professional services and is billed incrementally for periods of service less than 60 minutes. These other services may include report writing, telephone conversations over 15 minutes, attendance at meetings with other professionals at your request (e.g., IEP meetings), preparation of records or treatment summaries, and time spent performing any other services you request.

Field Visit Fees. A visit to school, home, or other community activity may be required as part of an assessment. The fee for a one-hour field visit is $275 within 25 miles of the Young Mind Center office. Any distance traveled over 25 miles will be billed at a rate of $3.50 per additional mile from the office. For example, a visit to a location that is 30 miles from the office would be an additional 5 miles, which would be a total of $292.50 [$275 + (5 × $3.50)]. The fee for a longer field visit increases incrementally at a rate of $200 per hour.

Legal Proceedings. Fees for expert witness testimony and legal proceedings are higher because of the involvement and complexities of each case. The fee for legal preparation and proceeding attendance is $400 per hour. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if one of our providers is called to testify by another party.

Specialty Services. Specialty therapy services, which includes those provided by our RBTs, BCBAs, SLPs, OTs, and other specialty providers are billed at hourly rates that vary depending on the specialty and range from $60 to $200 per hour.

Appointments & Cancellations

We will do our best to accommodate your schedule to permit you to set appointments with our office at a time that is convenient for you. To secure your appointment, we require a $50 booking fee and a credit card number to be placed

on file. You may always provide an alternative form of payment at the time of service, and your card will only be charged as outlined in this document. The booking fee will be applied to the cost of services rendered and will be refunded if services are covered by a third party (e.g., insurance, school district). _____ **Initial**

We require 24-hour notice if you must change or cancel an appointment. In the event that you must cancel your appointment without providing sufficient notice, your credit card on file will be billed $50. We will attempt to reschedule your appointment within the week to allow you to come in to the office for your missed appointment as soon as possible. _____ **Initial**

Clients who receive recurring therapy sessions must agree to abide by the policies set forth in the Clinical Services Agreement, which include information related to scheduling, modifying, and cancelling appointments. _____ **Initial**

Billing and Payment
Payment is due in full at the time service is rendered unless a payment plan has been prearranged. If you are using insurance and have already met any plan deductible, your co- payment as determined by your insurance provider is due at the time of service. If you have not met your deductible, you will be responsible for payment in full at the time of service until your deductible has been met. Please keep in mind that even if you are using insurance, your case may require services that are not covered, which are to be paid in full at the time of service. These uncovered services include testing and field visits. _____ **Initial**

Past Due Payments
If your account has not been paid for more than 60 days and payment arrangements have not been agreed upon, we may use any legal means available to us to secure the payment. If such legal action is necessary, the associated costs of collection will be included in the claim. In most collection situations, the only information released regarding a client's treatment is their name, the nature of the service provided, and the amount due. _____ **Initial**

Insurance Reimbursement
In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your services. If you have a health insurance policy, it will usually provide some coverage for mental health treatment; however, you (not your insurance company) are responsible for full payment of our fees. Any fees not paid by your insurance company will be billed to your credit card on file. For this reason, it is important that you determine exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. _____ **Initial**

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or, in rare cases, copies of the entire record. This information will become a part of the insurance company files and will probably be stored in a computer database. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical databank. We will provide you with a copy of any report submitted if you request it. _____ **Initial**

Contacting Us
Our professionals and staff may not be immediately available by telephone. In the event you need immediate assistance, please call 911 or go to the nearest emergency room. For non-emergency communication, you can leave a message on our confidential voicemail, which is checked regularly. Every effort will be made to return your phone call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform us of times you will be available. If your provider is unavailable for an extended holiday, they will provide you with the name of a colleague to contact, if necessary.

Professional Records
The law and standards of our profession require that we keep treatment records. You are entitled to receive a copy of your records, or we can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them in your provider's presence so that you can discuss the contents together. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Minors
For clients under 18 years of age, please be aware that the law might provide parents with the right to examine treatment records. We provide parents with general information about a minor's treatment with us, unless it is determined there is a high risk and the client poses serious harm to themselves or someone else. In this case, we will notify parents of our concern. We will also provide parents with a summary of treatment when completed. Before giving parents any information, the provider will discuss the matter with the minor, if possible, and do their best to handle any objections the minor may have about what the provider is prepared to discuss.

Confidentiality
In general, the law protects the privacy of all communications between a client and a treatment provider, and we can release information to others only with your written permission. However, there are some situations in which the treatment provider is legally obligated to act to protect others from harm, even if it means revealing some information about a client's treatment. For example:

- If it is believed that a child, elderly person, or disabled person, is being abused, your provider must file a report with the appropriate state agency;
- If it is believed a client is threatening serious bodily harm to another, your provider is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client;
- If the client threatens to harm himself or herself, your provider may be obligated to seek hospitalization for the client or to contact family members or others who can help provide protection.

Our providers may occasionally find it helpful to consult other professionals about a case. During a consultation, the provider makes every effort to avoid revealing the identity of the client. The consultant is also legally bound to keep the information confidential. If you do not object, you will not be informed of these consultations unless it is deemed important to treatment.

While these written exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not legal professionals.

Electronic Communication
By signing below, you also authorize the use of electronic mail for any and all correspondence with Young Mind Center, Young Mind Community Center and its treatment providers, including scheduling, information gathering, and for the delivery of reports and other official documents. You should understand that this means that confidential documents may be sent over the internet, which is not always a secure form of communication. Consent for electronic communication may be withdrawn at any time by notifying Young Mind Center in writing at the following address:
3202 E. Mountain View Rd., Phoenix, AZ 85028. _____ **Initial**

Audio/Video/Photography Consent
By signing below, you authorize your child/client to be audiotaped, videotaped, and/or photographed as needed for the purposes of treatment, progress monitoring, data collection, training, and identification. This information/material will not be shared with outside agencies/individuals or used for any other purposes without prior the written consent of parent/client. _____ **Initial**

I have been advised of the nature and probable results, the associated risks, and alternatives to the treatments and services offered by the Young Mind Center.

I,_____, consent to participate in, or authorize _____,
PRINT NAME OF PARENT/GUARDIAN PRINT CHILD'S NAME
to participate in assessment, evaluation, treatment and/or other services deemed necessary or advisable by Young Mind Center clinicians. I understand and agree to the policies outlined in this document.

_____ _____
PARENT/ GUARDIAN SIGNAURE DATE

young mind center

RECURRING CLINICAL SERVICES AGREEMENT

Child's Name: _____

Partnering with Families: Parent and family involvement is considered a best practice in early autism intervention and it is an essential component of our program. Our program emphasizes partnership, collaboration, and shared responsibility with parents so that parents can gain the knowledge, skills, and self-confidence needed to carry out the roles of caregiver, teacher, and advocate. _____ Initial

Parent Training Expectations: Parent training is an essential and mandatory component of our program. Optimum outcomes for children with autism require parent acquisition of interactive skills so they can foster interaction throughout the child's waking hours. One or both parents are required to attend the 12-week introductory training series that is held in center from 3:00 – 4:30p for 12 weeks. _____ Initial

Additionally, in-home training sessions are an essential and mandatory component of our program. One major goal of our program is establishing interactive environments at home and in other daily settings. A large part of our work with families involves coaching parents in the development and ongoing use of the interactive techniques covered in training. The frequency and duration of in-home training sessions are based on clinical recommendations and scheduled collaboratively with the parents. _____ Initial

We understand that emergencies and other scheduling conflicts arise and are sometimes unavoidable. We also know that when your child is absent they are missing valuable learning time and progress toward their goals could be threatened. The nature of our clinical services requires us to schedule a team member to work directly with your child. To retain skilled team members that we believe are the best in the field, we guarantee our full-time employees consistent income through salaried employment. We pay our team members even when your child is absent; however, we are unable to bill for missed services, which may ultimately threaten our organization's success. Accordingly, the policies below are to ensure your child's maximum development, respect our therapists' time, and protect the integrity of our services.

Scheduling Agreement: To maximize the consistency of our services, we utilize a semester scheduling system. Semester scheduling that plans in advance for school breaks, holidays, and vacations allows us to maximize our resources and programming and ensure the most consistent and, thus, effective services possible. Our semester format follows the school schedule:

- Fall: August – December
- Spring: January – May
- Summer: May – August

In order to have consistent services and appropriately schedule instructors, families are asked to carefully adhere to the schedule. We ask that scheduling changes are made between semesters, not during a semester. Once a schedule is developed and agreed upon, you are provided with a scheduling agreement. If scheduling changes must be made due to unforeseen circumstances, we ask that they are made in writing to the Logistics Director at least two weeks in advance. If you have an emergency and need to alter your child's schedule, please contact YMC as soon as possible.
_____ Initial

Scheduling Variables: There are many factors that influence the development of a treatment schedule. Variables include clinical recommendations, intensity and duration of program needs, the complexity and range of treatment goals, treatment authorizations, and therapist availability. We will do our best to accommodate requested days/times. However, please note that the aforementioned variables may impede certain requests. _____ Initial

Cancellations: In the event that your child is sick or unable to participate in a therapy session, you must directly notify the office as soon as possible. Each client is allotted 3 cancellations per semester. Cancellations in excess of 3 per semester will be charged $50 per session (this does not include changes made two weeks in advance). The $50 fee is charged to the client, not the insurance company, to help off-set the costs associated with the canceled session. _____ Initial

We have a limited amount of spaces. Clients with a trend of absenteeism could be subject to discontinuation in order to open the space for someone else. _____ Initial

Modifications: If you are more than 5 minutes late to your child's session or you require your child to be released prior to the end of their regularly scheduled session, you will be charged a prorated fee based on the private pay hourly rate of the provider rendering the services. For example, our private pay rate for RBT services is $60/hour, so if you are 20 minutes late dropping off your child for a session with an RBT, you will be charged $20. Similar to cancellations, each client is allotted 3 session changes each semester. The charge applies to every occurrence after the first three.
_____ Initial

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

PARENT/GUARDIAN SIGNATURE DATE

YMC REPRESENTATIVE SIGNATURE DATE

young mind center

INTAKE QUESTIONNAIRE

Please complete all items. Write N/A for items that do not apply to you. Note any item(s) that you are unsure how to answer. The psychologist/clinician will review the form with you and answer any questions during the initial interview.

First and last name of person completing form: _____

Relationship to client: _____ Date of completion: _____

Reason for Referral

Who referred you, or how did you find us? _____

What type of services are you seeking?

◯ Assessment ◯ Consultation ◯ Individual Therapy ◯ ABA Therapy ◯ Unsure

What are your concerns? (please use additional page(s) if needed) _____

_____

_____

_____

_____

How long have you had these concerns? _____

Do any of your family members or relatives have a similar problem? ◉ Yes ◯ No If yes, please note relation to client and age (if known) _____

What are your primary goals for this evaluation?

1. _____
2. _____
3. _____

Client/Child Information

Last Name: _____ First Name: _____ Middle Initial: _____

Nickname: _____ Gender: ◯ Male ◯ Female ◯ Non-binary/third gender

Date of Birth: _____ (month / day / year) Place of birth: _____ (city / state)

Address: _____ (street / city / state / zip code)

County of Residence: _____ School District of Residence: _____

Primary Phone: (_____) _____ E-mail: _____

Confidential voicemail? ◯ Yes ◯ No

With whom does the client live? _____

Educational Setting: ◯ Public ◯ Charter ◯ Private ◯ Homeschool ◯ Daycare ◯ N/A

Individualized Education Plan? ◯ Yes* ◯ No Educational Eligibility Category(s): _____

*If yes, please include copies of most recent MET and IEP reports.

School / Daycare Name(s): _____

School District: _____

Grade: _____ Teacher(s) / Instructor(s) Name: _____

Client's Employment Status: ◯ Employed ◯ Unemployed ◯ Never Employed

If employed or unemployed, list current or former employer: _____

Parent/Guardian Information

Parent/Guardian 1: ◯ Biological parent ◯ Adoptive parent ◯ Stepparent ◯ Guardian ◯ Other

Name: _____ Date of Birth: _____

Address: _____
street / city / state / zip code

County of Residence: _____ Home Phone: (_____) _____

E-mail: _____ Cell Phone: (_____) _____

Occupation (if applicable): _____ Work Phone: (_____) _____

Highest level of education completed: _____

Parent/Guardian 2: ◯ Biological parent ◯ Adoptive parent ◯ Stepparent ◯ Guardian ◯ Other

Name: _____ Date of Birth: _____
☐ check here if same address as Parent/Guardian 1 and skip to e-mail

Address: _____
street / city / state / zip code

County of Residence: _____ Home Phone: (_____) _____

E-mail: _____ Cell Phone: (_____) _____

Occupation (if applicable): _____ Work Phone: (_____) _____

Highest level of education completed: _____

Parent/Guardian Relationship Status:

◯ Married ◯ Domestic Partners ◯ Long-term relationship ◯ Divorced ◯ Separated ◯ Never married

Additional Parent(s)/Guardian(s): ◯ Adoptive parent(s) ◯ Stepparent(s) ◯ Guardian(s) ◯ Other

Name: _____ Date of Birth: _____

Address: _____

street / city / state / zip code

County of Residence: _____ Home Phone: (_____) _____

E-mail: _____ Cell Phone: (_____) _____

Occupation (if applicable): _____Work Phone: (_____) _____

Highest level of education completed: _____

Siblings: List all full, half, stepbrothers and sisters of child, in birth order.

Name	Gender	Age	Relationship to Child/Client	Live in Home
_____	_____	_____	_____	◯ Yes ◯ No
_____	_____	_____	_____	◯ Yes ◯ No
_____	_____	_____	_____	◯ Yes ◯ No
_____	_____	_____	_____	◯ Yes ◯ No
_____	_____	_____	_____	◯ Yes ◯ No
_____	_____	_____	_____	◯ Yes ◯ No

Other individuals living in the household: ◯ Yes ◯ No

If yes, list names and relationship to the child. _____

_____

Family History

Describe any history of developmental delays, learning difficulties, behavioral challenges, mental health disorders, and/or medical conditions in family members: _____

_____

_____

_____

_____

Developmental History

Did mother use any of the following during pregnancy?

Tobacco:	◯ Yes	◯ No	◯ Unknown	If yes, frequency:	◯ Occasionally	◯ Daily	◯ Weekly	◯ Unknown
Alcohol:	◯ Yes	◯ No	◯ Unknown	If yes, frequency:	◯ Occasionally	◯ Daily	◯ Weekly	◯ Unknown
Drugs:	◯ Yes	◯ No	◯ Unknown	If yes, frequency:	◯ Occasionally	◯ Daily	◯ Weekly	◯ Unknown

Planned pregnancy? O Yes O No
Natural conception? O Yes O No If no, please note procedure used: _____

Length of pregnancy:_____ Birth weight: _____

Delivery method (e.g., C-section): _____

Describe any difficulties or complications during pregnancy and/or delivery/post-delivery:_____

_____

_____

_____

Developmental Milestones

List age (in months) at which your child did the following: Check one: ◯ Approximated ◯ Exact

Motor	Language
Sat alone: _____	Babbling/Cooing: _____
Crawled: _____	First Words: _____
Stood alone: _____	Combined 2 words: _____
Walked alone: _____	Used 3-4 word sentences: _____

Please indicate any difficulties your child has had with the following:

Toileting: ◯ Current ◯ Past ◯ Never If ever, describe: _____
Eating: ◯ Current ◯ Past ◯ Never If ever, describe: _____
Sleeping: ◯ Current ◯ Past ◯ Never If ever, describe: _____

Medical & Behavioral Health History of Child/Client (Please use additional page if needed)
Primary Care Physician: ◯ Yes ◯ No

Name: _____ Specialty: _____

Address: _____
street / city / state / zip code

Phone: (_____) _____

Other Healthcare Provider(s): ◯ Yes ◯ No

Name: _____ Specialty: _____

Address: _____
street / city / state / zip code

Phone: (_____) _____

Name: _____ Specialty: _____

Address: _____
street / city / state / zip code

Phone: (_____) _____

Allergies, medical conditions, and/or mental health disorders? ◯ Yes ◯ No If yes, explain: _____

_____

_____

_____

Serious illnesses or hospitalizations? ◯ Yes ◯ No If yes, explain: _____

_____

_____

_____

List any medication or supplements child/client is receiving: (Please use additional pages, if needed)

Medication	Dosage	Time(s) given

Describe your child's eating habits: _____

Special diet and/or food allergies? ◯ Yes ◯ No If yes, explain: _____

_____

Social-Emotional & Behavioral History

Please indicate if you have concerns related to any of the following issues with your child/client, either currently or in the past:

- ◯ Does not follow instructions
- ◯ Difficulty paying attention
- ◯ Excessive crying/tantrums
- ◯ Difficulty interacting with peers
- ◯ Withdrawn/avoids interactions
- ◯ Unusual/repetitive behaviors
- ◯ Rigid behavior, routines, rituals
- ◯ Unhappy/sad
- ◯ Moody/irritable
- ◯ Anxious/worries
- ◯ Hypo-/hypersensitive to any of senses
- ◯ Harm to other people or animals
- ◯ Self-injurious behavior
- ◯ Preoccupations, obsessions
- ◯ Acts without thinking
- ◯ Overactive
- ◯ Underactive/lacks energy
- ◯ Excessive fears
- ◯ Overly familiar with strangers
- ◯ Unaware of environmental dangers
- ◯ Sexually precocious behavior

Has your child/client experienced any of the following?

- ◯ Move to a new home/school
- ◯ Death in the family
- ◯ Serious illness of family member
- ◯ Bullying
- ◯ Family financial stress
- ◯ Witnessed abuse
- ◯ Experienced abuse
- ◯ Neglect
- ◯ Parent separation/divorce
- ◯ Parental conflict
- ◯ Incarcerated parent
- ◯ Traumatic event

Previous Evaluations ◯ Yes* ◯ No

*If yes, please include copies of most recent MET and IEP reports.

Date (month/year)	Evaluator (name, credentials)	Facility (e.g., name of clinic)	Reason for Testing (e.g., delayed speech)

Educational History

List all schools attended, including preschool and/or daycare.

School/Facility Name	Type of Classroom (e.g., multi-age/grade, mainstream, integrated, self-contained, etc.)	Grade(s) (indicate if repeated)	Dates Attended (month/year – month/year)

Ever suspended or expelled? ◯ Yes ◯ No If yes, what grade(s)? _____

Explain incident & consequence/resolution: _____

_____

_____

_____

Services Received (Include current and previous services)

Type of Service (speech therapy)	Location (clinic, home, school)	Provider (name, credentials)	Duration/Frequency (60 min/wk)	Dates (6/10 – present)

Extracurricular / Group Activities (include social groups, clubs, sports teams, etc.)

Activity (e.g., soccer)	Organization/Location (city league)	Duration/Frequency (2hrs; 2x/week)	Dates (6/10 – present)

Community Organizations Resources

Does the client or your family participate in other community-based programs or resources? (e.g., religious group, support group, social services, etc.) ◯ Yes ◯ No If yes, please list: _____

_____

Strengths of the Child/Client and Family

Please tell us about your/your child's and family's strengths: _____

_____

Please tell us anything else you think would be helpful in understanding you or your child. Include any questions you may have.

_____

_____

_____

Thank you for taking the time to complete this questionnaire!

By signing this form, I attest the information provided is true and accurate to the best of my knowledge.

_____

Printed Name Signature Date

PAYMENT AGREEMENT FOR SERVICES

Child's Name: _____

PAYMENT INFORMATION

Payment for services is due at the time services are rendered. All balances must be paid in full prior to your final appointment. Payment plan options are available if needed; please inquire with the office administrator for more information. If you are using insurance, please keep in mind that you are responsible for any charges that are not covered by your insurance carrier, as verification of coverage for specific services does not guarantee claim payment for those services. Additionally, some services, including certain assessment measures and field visits, are not covered by insurance and are billed at private pay rates.

PRIVATE PAY FEES

Our private pay hourly fee is $200 for appointments and other professional services and may be broken down incrementally for periods of service less than 50 minutes. These other services may include report writing, telephone conversations over 15 minutes, meeting attendance (e.g., IEP meetings), preparation of records or treatment summaries, and time spent performing any other services you request. If you become involved in legal proceedings that require our participation, you will be charged for our professional time even if one of our doctors is called to testify by another party. Because of the involvement and complexities of legal proceedings, we charge $400 per hour for legal preparation and attendance.

Field visit fees include travel time. The fee for a one-hour field visit is $275 within 25 miles of the Young Mind Center. Any distance traveled over 25 miles will be billed at a rate of $3.50 per additional mile from the office. For example, a visit to a location 30 miles from the office would be an additional 5 miles and would be a total of $292.50 [$275 + (5 x $3.50)]. The fee for a longer field visit increases incrementally at a rate of $200 per hour.

BOOKING FEE & CANCELATION POLICY

Evaluation services require a $50 non-refundable booking fee to schedule an appointment. This fee will be applied to the services rendered. No refunds will be given for canceled appointments.

Young Mind Center requires 24 hours' notice if you must change or cancel an appointment. In the event that you must cancel your appointment without providing sufficient notice, your credit card on file will be charged $50.

PAYMENT OPTIONS

Automated Clearing House (ACH): ACH payments are those payments you have authorized YMC to process directly from your U.S. financial institution. It is a bank-to-bank transfer of funds that you have pre-approved for your expenses at YMC. Payments may be made from either your checking or savings account.

Credit Card: YMC will charge your payments directly to your credit card.

- YMC will email you an invoice prior to initiating payments for services rendered outside of office visits. _____ (initial)
- If you wish to stop ACH or credit card payments with YMC, you must notify YMC in writing at least five (5) business days in advance of a scheduled payment. I understand how to stop payments. _____ (initial)

RETURNED PAYMENTS

If a payment is returned, YMC will assess a $25.00 fee in addition to the fee your financial institution may impose. The $25.00 fee in addition to the payment due to YMC must be paid within two weeks or services may be suspended.

PRIVACY PRACTICES

YMC takes reasonable measures to protect the private financial data provided to YMC. In the event of a breach or suspected breach of confidential information, YMC will notify you within three (3) business days.

PAYER/RESPONSIBLE PARTY INFORMATION (To be completed by person responsible for making payments.)

LAST NAME _____ FIRST NAME _____

ADDRESS _____

CITY _____ STATE _____ COUNTRY _____ ZIP _____

MOBILE PHONE _____ WORK PHONE _____

EMAIL _____ PAYER'S DOB (REQUIRED) _____

PAYMENT INFORMATION (choose one)

1. Bank Payment

ROUTING NUMBER _____ ACCOUNT NUMBER (Non-business accounts only) _____

☐ Checking Account (attach voided check) ☐ Savings Account

FINANCIAL INSTITUTION NAME _____

CITY _____ STATE _____

PHONE _____

2. Credit Card Payment

☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover
(Check, Debit, or ATM Cards may be returned unpaid due to daily limit restrictions imposed by your bank.)

ACCOUNT NUMBER _____

EXPIRATION: MM/YYYY _____ CVV (4 digits on front AMEX) _____

PAYMENT AGREEMENT

By signing this agreement, I hereby agree to be the responsible party whether or not named as the responsible party above. I hereby accept and agree to be bound by the terms and conditions contained within this Payment Agreement for Services and authorize Young Mind Center to initiate debit/charge entries to the account listed or any subsequent account provided and to debit/charge the same such account. In the event that I am not the responsible party named above, then I shall be deemed to be the responsible party for all purposes under this Agreement.

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

PRINTED NAME OF RESPONSIBLE PARTY _____ DATE _____

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

young mind center

HIPAA NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes national standards to protect individuals' medical records and other personal health information (PHI) and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patient's rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

The Young Mind Center is committed to protecting your privacy and confidentiality to the fullest extent of the law. This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures that Do Not Require Your Authorization
Disclosure of your PHI without your authorization commonly includes, but is not limited to, the following disclosures:

For Treatment:

- We can use your health information and share it with other professionals who are treating you.

To Run our Organization:

- We can use and share your health information to run our facility, improve your care, and contact you when necessary.

To Bill for Services:

- We can use and share your health information to bill and get payment from health plans or other entities.

If Data is De-Identified:

- We can use and share health information which has been stripped of personally identifying information such as names, social security numbers, and dates of birth.

For Help with Public Safety Issues:

- We can share health information about you for certain situations, such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

For Research:

- We can use or share your information for health research.

To Comply with the Law:

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.

Address Workers Compensation, Law Enforcement, and Other Government Requests:

- We can use or share health information about you:
  - For workers' compensation claims;
  - For law enforcement purposes or with a law enforcement official;

- With health oversight agencies for activities authorized by law;
- For special government functions, such as military, national security; and presidential protective services.

Respond to Lawsuits and Other Legal Duties:

- We can share health information about you in response to a court or administrative order or in a response to a subpoena.
- Serious Threat to Health or Safety: If you communicate a serious threat of physical violence against an identifiable victim, the psychologist must make reasonable efforts to communicate that information to the potential victim and police. If the psychologist has reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, he/she may release relevant information as necessary to prevent the threatened danger.
- Child Abuse: Whenever a psychologist, in his/her professional capacity, has knowledge of or observes a child he/she knows or reasonably suspects, has been the victim of child abuse or neglect, the psychologist must immediately report such to the proper county authorities. If requested, the psychologist must turn over information from your records relevant to a child protective services investigation.

Uses and Disclosures Requiring Your Authorization

In order to use or disclose your PHI in situations other than those not permitted pursuant to HIPAA, we must obtain your written authorization. This authorization must be obtained before information is released. If you provide us with an authorization, you may revoke the authorization in writing, and this revocation will be effective for future disclosures of your medical information. However, the revocation will not be effective for information that we have already used or disclosed. Examples of these situations include releasing psychotherapy notes, for marketing purposes, and any disclosures that constitute the sale of medical information. It is the Young Mind Center's practice to participate in charitable events to raise awareness and funds for autism-related activities. During such times, we may send you a letter, postcard, invitation, or call your home to invite you to participate in the charitable activity. It is not our policy to disclose any PHI related to your treatment for the purpose of fundraising events sponsored by the Young Mind Center or the Young Mind Community Center.

Client's Rights and Psychologist's Duties

A client has the right to:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information with your health insurer for the purpose of payment or for our operations with your health insurer.
- Request and receive confidential communication of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are a client of the Young Mind Center. Upon your request, we will send any correspondence to another address.
- Request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request in writing within 60 days. On your request, we will discuss with you the details of the amendment process.
- Receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, we will discuss with you the details of the accounting process.
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- Phycologists are required by law to maintain the privacy of PHI and to provide you with this notice of their legal duties and privacy practices with respect to PHI.

Changes to This Notice and Your Choices

- We reserve the right to change the privacy policies and practices described in this notice and to make the new notice provisions effective for all PHI that is maintained. Unless we notify you of such changes, we are required to abide by the terms currently in effect.
- If we substantially revise our policies and procedures, we will immediately change this notice and place the revised version in the policy manual in our office. We will notify you verbally of such a change at your next appointment, and we will provide you with a paper copy of the revised notice upon request.
- For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
- If you are unable to tell us your preference (for example, if you are unconscious), we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the Young Mind Center at 602.237.6653.

- If you feel that we were unable to adequately address your concerns, you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to, calling, or visiting their website at:

200 Independence Avenue SW
Washington, DC 20201
1 (877) 696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/
We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Your signature below documents that Young Mind Center has given you the "Notice" attached to this Acknowledgment page.

By way of my signature, I acknowledge that Young Mind Center has given me a copy of the Privacy Notice as required by state and federal law. I understand and have been provided with the opportunity to review this Notice and discuss concerns I may have regarding the privacy of my information.

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

PARENT/GUARDIAN SIGNATURE DATE

YMC REPRESENTATIVE SIGNATURE DATE

young mind center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PURPOSE OF THIS RELEASE

The purpose of this release is to allow for the collaboration of care of the client.

NAME OF PERSON WHOSE INFORMATION IS BEING RELEASED

Name: _____ Date of Birth: _____

PRINT NAME OF CLIENT

Parent/Guardian: _____ Primary Phone: _____

PRINT NAME OF INDIVIDUAL PROVIDING AUTHORIZATION

Address: _____

NUMBER / STREET / CITY / STATE / ZIP CODE

The undersigned hereby authorizes you or any team member or employee of your office who has provided treatment to engage in oral discussion with and/or to release complete and legible copies of any and all written information concerning my physical and/or mental health condition, care, and treatment and disclose and deliver to:

To: _____

PROFESSIONAL'S NAME / TITLE / ORGANIZATION

Address: _____

NUMBER / STREET / SUITE / CITY / STATE / ZIP CODE

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED

This authorization shall provide for the release of any and all of my records as defined by A.R.S. § 12-2291, et seq. and includes but is not limited to:

- Session Notes
- Discharge Summaries
- Intake & Progress Reports
- Program Data
- Test Protocols
- Assessment Reports
- Billing Statements
- Photographs, videotapes, digital, other images

LIMITATIONS

This authorization also specifically authorizes the release of information pertaining to mental health diagnosis and/or treatment (A.R.S. § 36-509).

REDISCLOSURE

I understand that the Recipient, WITHOUT FURTHER AUTHORIZATION, may redisclose said information and the information may no longer be protected by the Medical Privacy Regulations promulgated under the Health Insurance Portability and Accountability Act (45 CFR §164.508).

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

- Right to Refuse to Sign this Authorization – I understand that I am under no obligation to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits.
- Right to Withdraw this Authorization – I understand that I may revoke this Authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires:

- ☐ One (1) year from the date set forth below
- ☐ On _____ (date)

A photocopy, or exact reproduction of this signed Authorization shall have the same force and effect as this original.

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

PARENT/GUARDIAN SIGNATURE DATE

YMC REPRESENTATIVE SIGNATURE DATE

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EXPLANATION OF CLIENT'S RIGHTS & RESPONSIBILITIES

You Have the Right:

1. To be treated with dignity, respect, and consideration.
2. Not to be discriminated against based on race, color, creed, sex, national origin, religion, sexual orientation, age, disability, marital status, diagnosis, or source of payment.
3. To receive treatment that:
    a. Supports and respects your individuality, choices, strengths, and abilities.
    b. Supports your personal liberty and only restricts your personal liberty in accordance with a court order; with your general consent; or as otherwise permitted.
    c. Is provided in the least restrictive environment that meets your treatment needs.
4. Not to be prevented or impeded from exercising your civil rights unless you have been adjudicated incompetent or a court of competent jurisdiction has found that you are unable to exercise a specific right or category of rights.
5. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation.
6. To have grievances considered in a fair, timely, and impartial manner.
7. To seek, speak to, and be assisted by legal counsel of your choice, at your expense.
8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising your rights.
9. If enrolled by the Arizona Department of Health Services or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the ADHS or the Department's designee in understanding, protecting, or exercising your rights.
10. To have your information and records kept confidential and released only as permitted under Arizona Administrative Code (AAC) R9-20-211(A)(3) and (B).
11. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
    a. For photographing for identification and administrative purposes, as provided by Arizona Revised Statutes (ARS) § 36-507(2).
    b. If receiving treatment, in accordance with ARS Title 36, Chapter 37.
    c. For video recordings used for security purposes that are maintained only on a temporary basis.
    d. As provided in AAC R9-20-602(A)(5).
12. To review, upon written request, your own records during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in AAC R9-20-211(A)(6).
13. To review the following at the agency or at the ADHS:
    a. The report of the most recent inspection of the premises conducted by the ADHS.
    b. A plan of correction in effect as required by the ADHS.
    c. If a report of inspection by a nationally recognized accreditation agency was submitted in lieu of an inspection conducted by the ADHS, the most recent report of inspection conducted by the nationally recognized accreditation agency.
    d. If a report of inspection by a nationally recognized accreditation agency was submitted in lieu of an inspection conducted by the ADHS, a plan of correction in effect as required by the nationally recognized accreditation agency.
14. To be informed of all fees that you are required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided in a crisis situation.
15. To receive a verbal explanation of your condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment.
16. To be offered or referred for the treatment specified in your treatment plan.
17. To receive a referral to another agency if the agency is unable to provide a behavioral health service that you request or that is indicated in your treatment plan.
18. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general

or informed consent to treatment, unless the treatment is ordered by a court in accordance with ARS Title 36, Chapter 5; is necessary to save your life or physical health; or is provided in accordance with ARS § 36- 512.

19. To be free from:
    a. Abuse
    b. Neglect
    c. Exploitation
    d. Coercion
    e. Manipulation
    f. Retaliation for submitting a complaint to the ADHS or another entity.
    g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to your treatment needs, except as established in a fee agreement signed by you or your parent, guardian, custodian, or agent.
    h. Treatment that involves the denial of:
        i. Food.
        ii. The opportunity to sleep.
        iii. The opportunity to use the toilet.
        iv. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.
20. To participate or, if applicable, to have your parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of your written treatment plan.
21. To control your own finances except as provided by ARS §36-507(5).
22. To participate or refuse to participate in religious activities.
23. To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene.
24. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of your treatment plan.
25. To participate or refuse to participate in research or experimental treatment.
26. To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment.
27. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings.
28. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility.

Persons with developmental disabilities have the same rights as other US citizens including the right to:

1. Be treated with dignity and respect.
2. Expect that the personnel caring for him/her will be current in skills and knowledge of their field of employment.
3. Be served without regard to race, color, creed, sex, national origin, religion, sexual orientation, age, disability, marital status, diagnosis, or source of payment.
4. Be protected from physical, psychological, verbal, or sexual abuse.
5. Access to public education.
6. Have equal employment opportunities and compensation.
7. Participate in placement evaluations.
8. Have an Individual Support Plan (ISP).
9. Access ISP notes and to participate in ISP and placement decisions.
10. Own, sell, or lease property; marry; petition.
11. Be presumed legally competent.
12. Live in a humane, clean environment; communicate; have visits; have personal property; and live in the least restrictive environment.
13. Withdraw from service.
14. Be informed of rights upon admission to service.

Under the Americans with Disabilities Act ("ADA"), the Young Mind Center must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. Pursuant to the ADA, a disability is defined

as a physical or mental impairment that substantially limits a major life activity. For example, this means that if necessary the Young Mind Center must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Young Mind Center will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact the Young Mind Center at (602) 237-6653.

You Have the Responsibility:

- To be honest about matters that relate to you as a patient.
- To make an effort to understand your health-care needs and ask your physician or other member of the healthcare team for information relating to your treatment.
- To provide staff with accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters pertaining to your health.
- To report any unexpected changes in your condition or symptoms.
- To follow the care, service or treatment plan developed and report any perceived risks in your care.
- To understand the consequences of the treatment alternatives and not following your plan of care.
- To be considerate and respectful of the rights of both fellow patients and staff.
- To honor the confidentiality and privacy of other patients.
- To follow the facility rules and regulations concerning patient care and conduct.
- To comply with our smoke-free environment policy.
- To be considerate of the facilities and property therein.
- To assure that the financial obligations of your healthcare are fulfilled as promptly as possible.
- To notify the ADHS Department of Consumer Relations if you feel your rights are being violated.

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INSURANCE VERIFICATION FORM

Child's Name: _____ DOB: _____

Policy Holder Name: _____ DOB: _____

Policy Holder's Address: _____

Policy Holder's Phone Number: _____

Insurance Carrier: _____

Provider Services Phone Number: _____
Include number for behavioral health if provided

Insurance Billing Address: _____

Member ID: _____ Group #: _____

Policy Holder's Employer (if applicable): _____

Group Plan Name: _____

The Young Mind Center has permission to contact my insurance carrier named above and discuss my coverage and services to be provided.

I understand that it is my responsibility to understand my insurance benefits. _____ Initial

I acknowledge that I am financially responsible for any and all charges not covered by my insurance carrier. _____ Initial

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

PARENT/GUARDIAN SIGNATURE DATE

YMC REPRESENTATIVE SIGNATURE DATE