JOHNSON BEHAVIORAL SERVICES PLLC

New Client Questionnaire

Please complete the information below. NOTE: Not all questions apply to your child. An initial intake will only be scheduled AFTER we have received this questionnaire via Fax, U.S. Mail or Direct Delivery to our office. Please see attached information regarding services.

A.

Child's Name *(Last, First, M.I.):*	M ☐ F ☐	**DOB:**
Referred by:		
Parent Name 1:	**Parent Name 2:**	
Primary Address		
Primary Phone number:	Home _____ Cell _____ Can I leave detailed messages at the above contact numbers? YES ☐ NO ☐	
In case of emergency contact:	Name of emergency contact _____ phone _____	

B.

	Therapy/Service	Provider Name
Please check all the services your child currently receives:	☐Speech Therapy: /week minute ☐Occupational Therapy /week minute ☐Physical Therapy /week minute ☐Other: ☐ School/Grade: Current IEP: ☐YES ☐NO ☐ABA Services in the past ☐YES ☐NO	

C.

PRIMARY INSURANCE INFORMATION (Please submit the front and back of your current insurance card with this form if you will be using your insurance)

Policy subscriber's name (if not patient):	Policy subscriber's DOB (if not patient):	
Name of Primary Insurance:	Primary Insurance Address:	Insurance Phone number:
Patient's relation to subscriber: ☐self ☐ spouse ☐ child ☐ other		
Patient Subscriber ID : Two-digit number if multiple members on the policy:	Group Number	Employer

Phone: (704) 277-7018
Fax 1-888-965-0596
Mail: 1150 Crews Rd STE F Matthews, NC 28105
Email: Katrina@JBSNC.com

JOHNSON BEHAVIORAL SERVICES PLLC

D.

Current Behavioral Concerns. Check ALL that apply:

Aggression (e.g. hitting, kicking, biting, scratching, pinching, hair pulling, head butting)	☐
Self-Injurious Behavior (e.g. biting self, scratching self, hitting self, pinching self, head banging self)	☐
Toileting (e.g. urination and/or defecation outside the toilet)	☐
Unsafe Behavior (e.g. running into the street, running out of the house, attempting to exit a moving vehicle)	☐
Pica (e.g. consuming or attempting to consume non-nutritive substance objects (does not include mouthing objects)	☐
Disruptive Behavior (e.g. frequent and loud yelling, verbal refusal, swiping or throwing objects)	☐
Property Destruction (e.g ripping, kicking, shattering, or otherwise devaluing property)	☐
Other: (Describe)	☐

How does your child communicate? Check ALL that apply:

Pointing/Gesturing	☐	1 or 2 signs (Sign language)	☐
Leading another with hand	☐	3 or more signs	☐
Standing next to what they want	☐	Augmentative communication device	☐
Whining	☐	1 to 2 words	☐
1 to 3 pictures (Picture Exchange Communication)	☐	2 to 4 phrases	☐
4 or more pictures (Picture Exchange Communication	☐	Complete, easily understandable sentences	☐

Current areas you would like to address in therapy. Please rate the following topics according to priority:

1 None	2 Low	3 Neutral	4 Moderate	5 High

Problem Behaviors					
Problem behavior (any form)	1	2	3	4	5
Self-injurious	1	2	3	4	5
Communication and Social Skills					
Functional communication with adults	1	2	3	4	5
Functional communication with peers	1	2	3	4	5
Conversational Skills	1	2	3	4	5
Social skills with peers	1	2	3	4	5
Play Skills	1	2	3	4	5
Attending/Academic Skills					
Impulsivity/hyperactivity	1	2	3	4	5
Attending during routine demands/Homework	1	2	3	4	5
Self-help Skills					
Toileting	1	2	3	4	5
Eating	1	2	3	4	5
Dressing	1	2	3	4	5

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JOHNSON BEHAVIORAL SERVICES PLLC

Overview of Therapy:

1. Therapy focuses primarily on promoting functional language development, increasing social skills, and minimizing problem behavior. In my therapeutic approach, I believe that behaviors are learned and focus on identifying consequences in the environment that maintain problem behavior. I develop very specific definitions of behaviors I want to increase or decrease and I will frequently ask your input as to "what the behavior looks like?" With your input, I can help you determine what is maintaining a behavior, teach you to change the environment to prevent behaviors, teach more appropriate replacement behaviors, and then develop a plan to teach those behaviors. I can also develop a plan to help you improve your skills in working with your child. Some of the time I will be working with the client directly and at other times I may be training significant others.

2. I will develop and review the treatment plan with you and ask that you sign the plan indicating that you understand and agree to the plan. Working with clients individually is more effective when parents and family partner with the client and therapist in the therapeutic process. One of the most unique aspects of treatment is that decisions are made based on objective data during the course of therapy. Interventions will be data driven and I will be showing you data as part of my ongoing evaluation of treatment. I will take baseline data to first determine the nature and extent of the target behaviors. Following direct observation and data collection, I will develop and continue to collect data to determine if it is effective. I may also request that you, family members, or other individuals who come in contact with your child collect a variety of data during the course of therapy.

3. Therapy may be conducted in office, home, or community settings, depending upon the needs of the child and prior approval if pursuing services via third party insurance.

5. Consistency is the most crucial component of therapy and inconsistencies may adversely affect your child's progress. Thus a great deal of work is required. If at any point in time it is determined that you or others who come into contact with your child are engaging in behaviors that are counterproductive to therapy, this will be discussed this with you directly.

6. Therapy involves a significant amount of time and work to be effective. It can be a slow process, so immediate results are not always obtained. With treatment, it is important to know behaviors may sometimes worsen before they improve. It often takes months for significant improvement to occur. However, with consistency, effective teaching procedures, and motivation, you can help your child make significant changes.

7. Therapy is not meant to continue indefinitely. The goal is to provide the family with useful skills so that they can begin to implement these new skills in order to help their child. The therapist will periodically evaluate your progress towards fading services.

8. Additional referral sources will be provided if the family and/or provider determine that this type of therapy is not a good fit for your child and family.

NOTE: Please see the Consent to Treatment form for additional information regarding services and policies & procedures.

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Fax 1-888-965-0596

JOHNSON BEHAVIORAL SERVICES PLLC

Effective Date: 11/4/13

NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information for the purposes of treatment, payment, and health care operations. HIPAA requires that I provide you with this Notice of Privacy Practices to inform you how I use and disclose Protected Health Information for treatment, payment, and health care operations. This Notice explains HIPAA and its application to Protected Health Information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although the information is detailed and sometimes complex, it is very important that you read it carefully before our work together can begin. We can discuss any questions you have about the procedures after you have read the entire document. When you sign this document, our Consent to Treatment, and other related documents, they will, together represent the agreement between you and my practice. You may revoke this Agreement in writing at any time. A revocation will not binding on me insofar as I have taken action in reliance on it, to the extent there are obligations imposed on me by your health insurer in order to process or substantiate claims make under our agreements, or if you have not satisfied any financial obligations you have incurred.

MY OBLIGATIONS:

I am required by law to:

- Maintain the privacy of protected health information
- Give you this notice of my legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that are currently in effect

The ensuing paragraphs explain how, when and why I may use and/or disclose your records which are known as "Protected Health Information" (PHI). Your PHI consists of individually identifiable information about your past, present, and future health and condition and the provision of and payment for health care to you. I may also receive your PHI from other sources, i.e. other health care providers, attorneys, etc. Your PHI receives certain protections under the law. Except in specified circumstances, I will not release your PHI to anyone. When disclosure is necessary under the law, I will only use and/or disclose the minimum amount of your PHI necessary.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION:

1. **Treatment**: I might conceivably use and/or disclose your PHI to psychologists, other behavior analysts, school, physicians, nurses, and other health care personnel involved in providing health care services to you, but only with your specific authorization. The only conceivable reason that a specific authorization might not be obtained would be in an emergency.
2. **Payment:** I may use and disclose PHI so that I may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, I may give your health plan information about you to determine benefits or so that they will pay for treatment.
3. **Health care operations**: I may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of my clients receive quality care and to operate and manage the various business functions of my office.
4. **Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services**. I may use and disclose PHI to contact you to remind you that you have an appointment with me. (i.e. if you are not home to receive a phone call, a message may be left on your answering machine or with a person in your household.)

5. **Health information:** I may also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
6. **Individuals Involved in Care or Payment for Care**. When appropriate, I may share PHI with a person who is involved in your care or payment for your care, such as your family or a close friend.

CONFIDENTIALITY AND SPECIAL CIRCUMSTANCES

Clients and their therapists have a confidential and privileged relationship. I do not disclose anything that is observed, discussed or related to clients. In addition, I limit the information that is recorded in your file to protect your privacy. However, please be aware that confidentiality has limitations which include the following circumstances:

(1) When I have your written consent to release information.
I will not disclose any information about you, your child, or the fact that your child is my patient, without your written consent. I will keep records on the services provided, dates of our sessions, assessments, plan for intervention, consultation, summary reports, and/or testing reports, and any release of information obtained. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operational purposes without your prior consent at the onset of services. You may revoke your permission, in writing, at any time, by contacting me.

(2) When I am verbally directed by you to convey information to another entity.

(3) When I determine that you are a danger to yourself or others.
Emergency: If the client is involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

(4) When I have reasonable grounds to suspect abuse or neglect of a child, disabled adult, or an elder adult.

Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by North Carolina law to report the matter immediately to the North Carolina Department of Social Services.

Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by North Carolina law to immediately make a report and provide relevant information to the North Carolina Department of Welfare or Social Services.

(5) When I am ordered by a judge to disclose information.
There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient. In most legal proceedings, you have the right to prevent me from providing any information about treatment. In some proceedings involving child custody and those in which the client's current functioning level is an important issue, a judge may request my testimony if he/she determines that the issues demand it. If you are involved in a court proceeding and a request is made for information concerning the professional services that I have provided, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a **court order**. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. PHI is disclosed in any litigation, etc. between the provider and the patient.

(6) When I use Electronic Transmissions
It is important to note many of the tools of modern communication may compromise confidentiality, such as computers, cell phones, email, portable phones, and faxes. I do use these forms of communication, but make every reasonable effort to protect your privacy. My computer is encrypted with a password and virus protection; however, ordinary privacy precautions such as passwords, pin codes, voice mail boxes, mail, and secured computers are not full-proof, so your confidentiality may be compromised when communicating via electronic devices, text, or email. E-mail communication should never be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. If you have an urgent matter please phone me directly, or call 911 or the mental health center emergency room (704-358-2700). In addition, you should be aware that any e-mail

communications may be made part of your permanent medical record. Signing this document indicates that you accept and understand the following inherent privacy risks involved:

1. Sent and received emails and texts are stored on both my and your computers and phones until deleted. There is no guarantee that I will save or delete such communication.
2. Whenever communicating via email, it possible for authorities and system administrators to locate and reach such emails under various circumstances. This is due to the nature in which email is transmitted using the internet and other services/networks.
3. You understand that I may use and disclose PHI to contact you via phone or email regarding appointment reminders and health related benefits (i.e. if you are not home to receive a phone call, a message may be left on your answering machine or with a person in your household.)

(7) When Consultation is helpful or necessary
As a Master's level psychologist, the North Carolina Psychology Board requires that I receive monthly supervision from a doctoral-level psychologist indefinitely as a practicing psychological associate. Information regarding your case will be discussed with my supervisor and I will disclose information only to the extent necessary to achieve the purpose of consultation. At times, I may also consult with professional colleagues about aspects of your case. Your name and unique identifying characteristics will not be disclosed. The professional is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. My professional records are separately maintained and no other individuals can have access to them without your specific, written permission.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential issues, it is important that we discuss any questions or concerns you may have no or at any time in the future. I 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 I am not an attorney.

The HIPAA Privacy Rule grants you each of the following individual rights:

1. ***Right to Inspect and Copy***. You have the right to view your PHI that is in my possession or to obtain copies of it. You can request these records at any time. Because these are professional records, though, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. I require a completed and signed written Request and Authorization for Release of Health Information Form before releasing any documents to anyone, including the patient. The form must be completed, dated and signed, and I ask that you specify what components of your medical records you wish to obtain. Under certain circumstances, such as if I fear the information may be harmful to you, I may deny your request. If your request is denied, you will be given in writing the reasons for the denial. I will also explain your right to have my denial reviewed. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree in advance to it, as well as to the cost.

2. ***Right to Get Notice of a Breach.*** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

3. ***Right to Amend***. If you feel that the PHI we have is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Johnson Behavioral Services, PLLC.

4. ***Right to an Accounting of Disclosures***. You have the right to request a list of certain disclosures I have made of your PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Johnson Behavioral Services, PLLC.

5. ***Right to Request Restrictions***. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations.

6. ***Right to Request Confidential Communications***. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Johnson Behavioral Services, PLLC. Your request must specify how or where you wish to be contacted. I will accommodate reasonable requests.

CHANGES TO NOTICE:

I reserve the right to change this notice and make the new notice apply to Health Information I already have, as well as any information I receive in the future. I will email you or provide you with a copy of my current notice. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe that I may have violated your individual privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint (in writing) to me at 1020 Crews Rd, Suite M, Matthews, NC 28105. If you prefer, you may file your written complaint with the Secretary of the Department of Health and Human Services at 2001 Mail Service Center Raleigh, NC 27699-2001. You will not be penalized for filing a complaint.

This HIPAA document is for your records. Please sign below on your behalf and on behalf of the patient, indicating you have read, understand, and have had the opportunity to ask questions regarding our Privacy Notice.

On behalf of yourself:

_____ _____ _____
Print Name (Parent/Legal Guardian) (1) Signature (Parent/Legal Guardian) (1) Date

_____ _____ _____
Print Name (Parent/Legal Guardian) (2) Signature (Parent/Legal Guardian) (2) Date

On behalf of the patient:

_____ _____ _____
Print Name (Parent/Legal Guardian) (1) Signature (Parent/Legal Guardian) (1) Date

_____ _____ _____
Print Name (Parent/Legal Guardian) (2) Signature (Parent/Legal Guardian) (2) Date

_____ _____
Signature (Psychologist/BCBA) Date

Phone: (704) 277-7018 Mail: 1150 Crews Rd STE F Matthews, NC 28105 Email: Katrina@JBSNC.com
Fax 1-888-965-0596

Effective Date: *8/12/22* **Consent to Treatment and Client Agreement**

Thank you for taking an interest in my practice. This document contains important information about my professional services and business policies. It includes the obligations of the therapist and also some expectations of you as the client. It is important that you read it carefully and ask any questions you might have so we can discuss them during our next scheduled meeting. When you sign this document, our HIPAA Privacy Notice, and other related documents, it will, together, represent the agreement between you and my practice and ensures that you understand our professional relationship. You may revoke this Agreement in writing at any time. Please initial each page of the document after reading each page and keep a copy for your records.

SERVICES, PROFESSIONAL RELATIONSHIP, LIMITATIONS AND RISKS

My Qualifications:

I am licensed psychological associate who specializes in working with children and adolescents who exhibit problem behaviors. I received my Master's in Clinical Psychology with a specialization in Applied Behavior Analysis from East Carolina University in 2008. In addition to being licensed in the state of North Carolina as a Master's level psychologist, I am also a board certified behavior analyst (BCBA). My primary training and experience has been in applied behavior analysis, which is a unique method of treatment grounded in the idea that behavior is learned over time and it is maintained by consequences in the environment.

Treatment Approach:

My practice focuses primarily on promoting functional language development and minimizing problem behavior. In my therapeutic approach, I believe that behaviors are learned and focus on identifying consequences in the environment that maintain problem behavior. I develop very specific definitions of behaviors I want to increase or decrease and I will frequently ask your input as to "what the behavior looks like?" With your input, I can help you determine what is maintaining a behavior, teach you to change the environment to prevent behaviors, teach more appropriate replacement behaviors, and then develop a plan to teach those behaviors. I can also develop a plan to help you improve your skills in working with the client Some of the time I will be working with the client directly and at other times I may be training significant others. Working with clients individually is more effective when parents and family partner with the client and therapist in the therapeutic process. I write specific goals that address your priorities communicated at the onset of and throughout services. I will also write goals that I believe are clinically necessary to address the needs of the client. If data indicates a specific intervention is not effective, I will communicate this directly to you and develop a more effective intervention. The treatment plan is a fluid document and I will explain my assessment and the results of my assessment in language you can understand.

Risks/Benefits:

As with any therapy, there are risks and benefits and it is impossible to guarantee any specific results or timeline regarding treatment results. With treatment, it is important to know the client's behaviors may sometimes worsen before behaviors improve. However, therapy has many potential benefits, including minimizing maladaptive behaviors, increasing functional communication skills and replacement behaviors, and improving your skills in interacting with your child. At any point, if you have questions about my procedures, we should discuss them whenever they arise. I will work with you to insure your family receives the best quality services possible, including helping you locate another professional for a second opinion or treatment, if so desired.

Code of Conduct:

I am governed by various laws and regulations and by the code of ethics of my profession. As a professional, I will use my knowledge and skills within my scope of practice to help you as best I can. I am required to adhere to The American Psychological Association's *(APA) Ethical Principles of Psychologists and Code of Conduct* ® and the *Guidelines for Responsible Conduct* of the Behavior Analyst Certification Board®.

JOHNSON BEHAVIORAL SERVICES PLLC

Termination:
Please know that you are not obligated to seek services with me and you have the right to terminate services at any time. If it is determined that you wish to terminate services, I will provide you with a list of appropriate resources for other professionals/services. There may also be reason for me to terminate services as well. The reasons I may terminate a therapeutic relationship would include a failure to meet the terms of our fee agreement, a need for services outside of my scope of practice, or if I believe my consultation has become non-productive (i.e. people who interact with the client are engaging in behaviors that are counterproductive to the treatment plan) Should any of these situations arise, the reason for termination will be discussed with you and I will assist you in making alternative plans for care, including providing referral information.

CLIENT RESPONSIBILITIES

Treatment Plan:

I will develop and review the treatment plan with you and ask that you sign the plan indicating that you understand and agree to the plan. Consistency is the most crucial component of my therapy and inconsistencies may adversely affect the client's progress. If at any point in time it is determined that you or others who come into contact with the client are engaging in behaviors that are counterproductive to the treatment plan, I will discuss this with you directly. I can only work with clients who fully communicate their needs and concerns regarding treatment. I will be asking a lot of questions and will develop intervention strategies based upon information gathered from direct observation of the client and indirectly from your responses. My interventions will be data driven and I will be showing you data as part of my ongoing evaluation of treatment.

Progress Monitoring:

One of the most unique aspects of my treatment is that decisions are made based on objective data during the course of therapy. I will take baseline data to first determine the nature and extent of the target behaviors. Following direct observation and data collection, I will develop and continue to collect data to determine if it is effective. I will show you this data and will make changes in treatment based on this data. I will also request that you, family members, or other individuals who come in contact with the client collect a variety of data during the course of therapy.

Supervision Policy

For services rendered in the home, I request that you be present in the home for the duration of the session. Please note that I am not able to provide any supplements and/or medications directly to the client or transport the client.

Dual Relationships:

Under my code of ethical conduct, I have an ethical responsibility not to develop personal friendships with clients or your immediate family members during the course of therapy. Although our relationship involves very personal interactions and discussions, I need you to understand that we have a professional relationship rather than a social one. I make every effort to avoid outing you as one of my clients. Thus, if we happen to encounter each other in a social setting, I will not approach you or initiate contact unless you initiate contact first. Moreover, even if you initiate contact, I may limit any contact initiated by you. My behavior is not intended to be personal; rather, my behavior is intended to protect your confidentiality. It is not appropriate for me to communicate via social media, accept gifts or meals, or be involved with your personal activities such as birthday parties, or family outings. In addition to personal relationships, my services are intended to treat the client and provide family training, as appropriate. Although family members are often actively involved in therapy, I can only provide recommendations that are relevant to the needs of the client. I will not conduct individual therapy with any family members regarding issues that are not relevant to the client's care; however, I will make appropriate referrals and/or provide you with resources that may best meet your specific needs. If a potentially

consuming, harmful or inappropriate relationship is arising or has arisen, I will take reasonable steps to resolve it with due regards for the best interest of the client and maximal compliance with my ethics code

APPOINTMENTS, FEES, AND EMERGENCIES

Missed Appointments/Cancellation

I expect that if you need to cancel or reschedule your appointment that you will call as soon as you are aware of the change. Please ensure that you give at least 24 hour- notice if your child exhibits any of the following (includes, but is not limited to, a fever at or above 100, vomiting, sinus infection or flu-like symptoms, viral infections, pink eye, lice, strep throat). Insurance carriers will not pay for missed appointments or late cancellations. You can leave a voice message. Please do not email cancellations. If I do not receive 24-hour notification of your cancellation or you fail to show for an appointment, then you will be charged a $50 cancellation fee for the appointment. I understand that emergency situations arise, on both ends (provider and parents), and these situations will be handled on a case-by-case basis**.**

Fees:

The current fee for my services is $150 for the intake and $_135_ per hour for family, individual therapy and ABA therapy. This includes direct therapy with the client, observations, family training, planning, writing, and preparing reports, and attending meetings. Please see the financial policy for additional information regarding fees and payment. If you are receiving services via a third party I have prior arrangements with, you will be required to pay your copay deductible, or co-insurance at the time of service. If you are private pay or insured by a plan that I do not have a prior arrangement with ("out of network"), you will be responsible for the complete charge at the time of service. I require payment be made at the time of services For payment plans previously set up, payments on invoices are expected within thirty days or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. In most collections situations, the only information I release regarding a patient is his/her name, the nature of services provided, and the amount owed.

Health Insurance:

If you are receiving services via a third party, my services may or may not reimbursable within your benefits. You will need to verify this with your insurance carrier. I will assist you by submitting claims electronically for each visit. You will be required to pay your copay, deductible, or co-insurance at the time of service. If you are insured by a plan that I do not have a prior arrangement with, I will provide you with a detailed statement that you may submit to your insurance to obtain out-of-network reimbursement. However, you, and not your health insurance carrier, are responsible for full payment of my fees (with the exception of clients with approved sessions by accepted insurance companies and in some single case agreements). You are responsible for services not covered by the insurance carrier, including, but not limited to, copayments, coinsurance, and uncovered or ineligible services, as well as all charges for services provided over the maximum allowable benefit for the calendar year. If the client's insurance company denies payment, you are responsible for payment. Clients who change insurance companies must notify the therapist immediately. There are some companies that provide specific coverage for ABA; however, they often require an authorization through specific carriers and the establishment of an agreement between the provider and the carrier. Please be aware that insurance companies require a formal diagnosis with their claims. Please know that disclosure of confidential information may be required by your carrier in order to process the claims. By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment.

PROFESSIONAL RECORDS

All complete records will remain on file for a minimum of seven years after the last contact with the client and, if the client is a minor, the records will be maintained until three years after the age of majority. You can request these records

at any time. You may also be charged a fee for any preparation time which is required to comply with an information request.

INFORMED CONSENT FOR COMPUTER, TELEPHONE, ELECTRONIC, AND MAIL CONTACT

It is important to note many of the tools of modern communication may compromise confidentiality, such as computers, cell phones, email, portable phones, and faxes. I do use these forms of communication, but make every reasonable effort to protect your privacy. My computer is encrypted with a password and virus protection; however, ordinary privacy precautions such as passwords, pin codes, voice mail boxes, mail, and secured computers are not full-proof, so your confidentiality may be compromised when communicating via electronic devices or mail. Your use of such means of communication with me constitutes implied consent for reciprocal use of electronic or mail communications as well. I will make every effort to return your email within 48 business hours; however, I cannot guarantee a response time period due to time constraints of the practice. E-mail communication should never be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. If you have an urgent matter please call me directly, or call 911 or the mental health center emergency room (704-358-2700). In addition, you should be aware that any e-mail communications may be made part of your permanent medical record. Signing this document indicates that you accept and understand the following inherent privacy risks involved:

1. Sent and received emails are stored on both my and your computers until deleted. There is no guarantee that I will save or delete such email communication. Any saved emails are kept in a password-protected account that only I have access to.
2. Whenever communicating via email, it possible for authorities and system administrators to locate and reach such emails under various circumstances. This is due to the nature in which email is transmitted using the internet and other services/networks.
3. You understand that I may use and disclose PHI to contact me via phone or email regarding appointment reminders and health related benefits (i.e. if you are not home to receive a phone call, a message may be left on your answering machine or with a person in your household.)
4. By singing this document, you understand and agree the disclosures listed above regarding communication with me via email, phone, fax, and mail.

Print Name: _____ Signature_____ Date: _____

Print your email: _____

CHANGES TO NOTICE/POLICIES:

I reserve the right to change this notice and make the new notice apply to Health Information I already have, as well as any information I receive in the future. From time to time, I may also change the business policies described in this document. I will make every attempt to inform you of relevant changes. I will post a copy of my current privacy notice at my office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe that I may have violated your individual privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint (in writing) to me. If you prefer, you may file your written complaint with the Secretary of the Department of Health and Human Services at (919) 855-4800 (See Grievance Policy for additional information.)You will not be penalized for filing a complaint.

JOHNSON BEHAVIORAL SERVICES PLLC

PHOTO/VIDEOTAPE CONSENT AND RELEASE:

I grant Johnson Behavioral Services, the full right to use my child's photographs, videotaped images, and sound recordings as a part of staff/family training, educational seminars, and promotional efforts. I understand that they may be used for educational/promotional purposes.

YES ☐ NO ☐ Initials: ____

Your signature below indicates that you have the read the information is this consent to treatment document and agree to abide by its terms during our professional relationship. This document is for your records. Please sign the attached form on your behalf and on behalf of the patient, indicating you have read, understand, and have had the opportunity to ask questions regarding the information in this document.

On behalf of yourself:

_____ _____ _____

Print Name (Parent/Legal Guardian) (1) Signature (Parent/Legal Guardian) (1) Date

_____ _____ _____

Print Name (Parent/Legal Guardian) (2) Signature (Parent/Legal Guardian) (2) Date

On behalf of the patient:

_____ _____ _____

Print Name (Parent/Legal Guardian) (1) Signature (Parent/Legal Guardian) (1) Date

_____ _____ _____

Print Name (Parent/Legal Guardian) (2) Signature (Parent/Legal Guardian) (2) Date

_____ _____

Signature (Psychologist/BCBA) Date

Phone: (704) 277-7018 Mail: 1150 Crews Rd STE F Matthews, NC 28105 Email: Katrina@JBSNC.com
Fax 1-888-965-0596

JOHNSON BEHAVIORAL SERVICES PLLC

I am dedicated to providing the best possible care for your child and I want you to completely understand my financial policies and best faith estimates below:.

1. All clients paying privately or who have a copay or deducible responsibility, I will require that payment be rendered either via card or check at the time of services. The agreed contracted rate for the initial intake is $150 and $135/hr for ABA, individual, and family therapy.

2. If you are insured by a plan that I do not have a prior agreement with (non-provider, "out of network), I will provide you with a detailed invoice called a "Superbill" that you can then submit to your insurance company on an unassigned basis. This means the insurer will send the payment directly to you and you will responsible for the complete charge. You are responsible for the full amount at the time of service. I encourage you to follow up with your insurance provider to explore your "out of network" benefits, as a percentage of my services may be reimbursable.

Questions you might ask your insurance provider include:

- Do I have out-of-network benefits to see a mental health provider? If so, what percentage do you cover and how much is the allowed amount for the following (90847, 90846, 90791, 90837)
- Are there any exclusions? (i.e diagnosis)
- What is the deductible, and how much of the deductible have I met?
- What is my co-pay if I see an out-of-network provider in the home setting vs office setting?
- How do I access the form(s) needed to submit a request for reimbursement for out of network?

I authorize the provider to make electronic payments via Square and/or sign on my behalf (if I request the credit card to be kept on file and monthly payments are due).

3. If prior arrangements are made with your insurance carrier to accept an assignment of benefits, I will assist you by submitting claims electronically for each visit, and will likely call your insurance company to double-check your benefits. You are required to pay your deductible, co-payment or co-insurance at the time of service. I can provide a detailed invoice of services upon request.

4. Not all insurance plans cover all services. These services might include ABA therapy, family therapy, attending school meetings, conducting a home visit, or conducting a school observation. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge.

I have read and understand the financial policy of Johnson Behavioral Services, PLLC and I agree to be bound by its terms and agree to assign the benefits to the therapist (if applicable). I also understand and agree that such terms may be amended by the practice from time to time. I hereby authorize the release of medical information including complete medical records, assessments, and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that information will be used to review, investigate, or make payment of a claim, and to review records for audit compliance, utilization management, and complaint resolution. I authorize payment directly to Johnson Behavioral Services, PLLC for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

_____/_____ _____/_____

Signature of Parent (1) Date Print Name of Parent (1) Date

_____/_____ _____/_____

Signature of Parent (2) Date Print Name of Parent (2) Date

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JOHNSON BEHAVIORAL SERVICES PLLC

PATIENT BILL OF RIGHTS

As a patient, family member, or responsible guardian, you have the right to:

Care regardless of race, color, creed, sex, religion, or national origin.

Be treated with courtesy and respect for your individuality. Case discussion, consultation, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toilet training (if applicable) and other activities of personal hygiene, except as needed for patient safety or assistance.

Be assured confidential treatment of your personal and medical records, and you may request a restriction or limitation on the health information that is disclosed. You will be informed of the practice's policy regarding the disclosure of your clinical records for any purpose.

Have the right to prompt and reasonable responses to your questions and requests.

Be referred to an alternative service if the practice is unable to provide necessary care or for any reason denies service to you.

Request information in advance of any changes in the plan of care and participate in planning your treatment or any changes in your treatment.

Be informed in advance of any changes in the plan of care before being made.

Be informed in the discipline of Applied Behavior Analysis.

Review your clinical record. The provider will assist you in understanding your records by being available to answer questions and to explain the meaning of technical terminology.

Be informed of the State Home Health Hotline number which is established to receive complaints or answer questions regarding home health care. North Carolina Home Health Care and Health Care Complaint Line 1-800- 624-3004.

Be informed of the North Carolina Disability Rights and Resources organization. The Charlotte contact number is 704-537-0550 and additional information can be found at www.disability.gov

GRIEVANCE PROCEDURE

All patients of Johnson Behavioral Services, PLLC are afforded patient rights in accordance with state law and associates. Any patient who has reason to believe that he/she has been unfairly denied their stated rights may file a grievance without fear of reprisal in any way. Johnson Behavioral Services, PLLC will address all complaints and grievances received. If you feel as though your concerns have still not been resolved, feel free to contact the following:

Secretary of the Department of Health and Human Services
(919) 855-4800
2001 Mail Service Center
Raleigh, NC 27699-2001

North Carolina Psychology Board
(828) 262-2258
895 State Farm Rd, Ste. 101
Boone, NC 28607

I have read and understand the Patient Bill of Rights and Grievance Procedure.

Patient name: _____

Parent Name: _____

Parent Signature: _____ Date: _____

JOHNSON BEHAVIORAL SERVICES PLLC

Consent for Release of Information/Request for Information Form

I understand that Johnson Behavioral Services, PLLC has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Johnson Behavioral Services, PLLC to release some of my personal information to certain individuals or agencies.

I, _____, (guardian)hereby authorize Johnson Behavioral Services, PLLC to

release/obtain the following specific information regarding _____(name of client) with:

Organization to receive records/information:		**Organization to provide records/information:**	
Name	_____	Name	_____
Phone	_____	Phone	_____

The information may be shared: ☐in person ☐by phone ☐by fax ☐ by mail ☐by e-mail

Information permitted to share	☐Plan of Care ☐Behavior Plan/Data ☐Consultative Feedback ☐Exit Plan ☐Data ☐Assessments ☐Diagnosis ☐OTHER:

Please Note: there is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by Johnson Behavioral Services, PLLC

Patient's Rights and Responsibilities:

☐I understand that authorizing the disclosure of private health information is voluntary and I do not have to sign this form and that this release is limited to what I write above. If I would like Johnson Behavioral Services, PLLC to release or obtain information about me in the future, I will need to sign another written, time-limited release.

☐I understand that releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Johnson Behavioral Services, PLLC.

☐I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

This release will be valid for 1 year from

☐_____/_____ OR ☐ Two weeks post-service exit
mm/dd/yyyy time

Signed: _____ **Date:** _____

Phone: (704) 277-7018 Mail: 1020 Crews Rd STE M Matthews, NC 28105 Email: Katrina@JBSNC.com
Fax 1-888-965-0596

JOHNSON BEHAVIORAL SERVICES PLLC

Late Cancelation or "no show" Policy

We ask that parents give 24 hours' notice for Cancelations, in the form of a phone call and voice mail to the therapist. Please do not email Cancelations. Please ensure that you give at least 24 hour-notice if your child exhibits any of the following (includes, but is not limited to, a fever at or above 100, vomiting, sinus infection or flu-like symptoms, viral infections, pink eye, lice, strep throat). Cancelations (or "no shows") without 24 hours' notice are subject to a Cancelation fee of $50. The therapist will bill for this at a rate of $50/hour or session and the family will be responsible for this fee. Insurance carriers will not pay for missed appointments, late Cancelations, or late arrival. The therapist will contact the family after 15 minutes has passed and inform them that they are leaving, (unless the parent is near-by and both parties agree to have session). If the therapist attempts to reach the family unsuccessfully, the therapist should attempt to leave a voicemail stating that the session is cancelled. This policy is also in effect for sessions at school when the child is not present at the stated session start time. This policy is also in effect for sessions at school when the child is not present at the stated session start time.

Please understand that these policies are in place in order for the therapist to best meet the needs of the clients. We understand that emergency situations arise, on both ends (therapist and parents), and these situations will be handled on a case-by-case basis. Johnson Behavioral Services is also expected to give 24 hours' notice for Cancelations and are expected to call if they will be late due to traffic or other unforeseen circumstances. We appreciate your understanding of the need for these policies as we continue to provide services to your family.

I have read and understand the Cancelation Policy.

Parent Signature: _____ Date: _____

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Fax 1-888-965-0596

JOHNSON BEHAVIORAL SERVICES PLLC

COVID-19 Consent Waiver

I, _____, hereby consent for my child (name of client) _____ to receive therapy from Johnson Behavioral Services, PLLC during the COVID-19 outbreak. I understand there is much to learn about the newly emerged COVID-19 including how it spreads and is transmitted. I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that myself, child or any immediate family members do not display or currently have any of the symptoms that are representative of COVID- 19, which are outlined above: ___ (Initial)

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival. ____ (Initial)

I confirm that our family has not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____(Initial)

I confirm, to the best of my knowledge, that myself, child or any immediate family members have not had close contact with an individual diagnosed with COVID-19 in the past 14 days. _____ (Initial)

Parent Signature::_____ Date:_____

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