Across the Board
THERAPY GROUP

SPEECH • BEHAVIORAL/ABA • OCCUPATIONAL • PHYSICAL

Welcome to Across the Board Therapy Group Applied Behavior Analysis “ABA” program we look forward to working with you and your family. Below you will find a list of items we will need you to complete before your first appointment.

☐ PLEASE CALL YOUR PRIMARY PHYSICIAN AND REQUEST REFERRAL & AUTHORIZATION FOR ABA.

☐ PLEASE VERIFY THAT YOU HAVE AUTHORIZATION WITHIN 48 HRS OF YOUR APPOINTMENT.

☐ PLEASE COMPLETE THE INTAKE PACKET & RETURN TO THE FRONT OFFICE WITHIN 48 HRS OF YOUR APPOINTMENT.

☐ PLEASE HAVE A COPY OF YOUR CHILD’S IEP, IF APPLICABLE.

☐ PLEASE HAVE YOUR INSURANCE CARD & DRIVERS LICENSE ON THE DAY OF EVAL.

☐ IF YOUR CHILD HAS RECEIVED SERVICES AT ANOTHER CLINIC PLEASE COMPLETE & SIGN PAGE 20. PLEASE INCLUDE PREVIOUS FACILITIES CONTACT INFORMATION FOR RECORD RELEASE.

☐ PLEASE FEEL FREE TO CALL OUR OFFICE IF YOU HAVE ANY QUESTIONS.

(850)939-3944
7552 NAVARRE PKWY STE. 32
NAVARRE, FL
32566

Across the Board THERAPY GROUP
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7552 Navarre Parkway, Unite 32
Navarre, Fl 32566
Phone: (850)939-3944
Fax: (850)939-3945

Confidential

The following questionnaire is to be completed by the client's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding your client, Across the Board Therapy Group, LLC will hold information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the back of the pages for additional information.

Please Print

Name of Person Completing this form:_____

Legal Name of Client: _____

Nickname or name client routinely goes by:_____

Client's Date of Birth:_____ Age:_____

Home Address:_____

street

_____ _____ _____

city state zip

Home Telephone Number:_____-_____-_____

Work Telephone Number(s):

Mom _____-_____-_____

Dad _____-_____-_____

Cell Phone Number(s):

Mom _____-_____-_____

Dad _____-_____-_____

Primary Insurance:
ID #:
Group #:
Name of Insured:
Date of Birth of insured:
Phone Number:
Secondary Insurance:
ID #:
Group #:
Name of Insured:
Date of Birth of insured:
Phone Number:

School Name: _____ System:_____ Grade: _____

School Telephone Number:_____

Current Teacher(s):_____

Who referred you to our practice?

_____

Please describe the problems your client is having now, and what type of services you are seeking from us for these problems.

_____

_____

(Attach an additional page if needed)

Parent/ Guardians

Marital Status: Married - Remarried - Divorced - Separated - Widowed - Single - Cohabitants

- If divorced, who has physical custody? _____ Is it full or joint? _____
- Who has legal custody? _____Is it full or joint? _____
- If divorced, please provide a copy of the custody agreement.

Mothers Name: _____

Date of Birth:_____Age: _____

Occupation:_____Email:_____

Employer:_____(if Military) Rank:_____

Education Completed_____Health:_____Excellent____Good_____Fair_____Poor

Does the mother's job require her to be away from home long hours or extended periods?_____

If yes, please explain:_____

Fathers Name: _____

Date of Birth:_____Age:_____

Occupation:_____Email:_____

Employer:_____(If Military) Rank:_____

Education Completed_____ Health:_____Excellent____Good_____Fair_____Poor

Does the father's job require her to be away from home long hours or extended periods?_____

If yes, please explain:_____

Siblings:

Name_____Grade_____Age_____ Relationship_____

Live in _____ Y _____ N School_____

Name_____Grade_____ Age_____ Relationship_____

Live in _____Y_____N School _____

Name _____Grade_____Age_____ Relationship_____

Live in _____Y_____N School_____

Name _____Grade_____Age_____ Relationship_____

Live in _____Y_____N School_____

Has the client you are seeking services for been evaluated in the past? Yes / No

If yes please list the following information on the previous evaluation (s)

Who	Type	When	Copy Available

(Attach an additional page if needed)

If Yes, what were their general findings and recommendations?

_____

_____

_____

_____

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your client:

_____

_____

_____

_____

_____

Prenatal & Delivery History :

Were there any complications with the Pregnancy? _____Y ____N

If Yes, please provide details: _____

_____

_____

Were there any complications with Delivery? _____Y ____N

If Yes , please provide details: _____

_____

_____

_____

Were there any any concerns at Birth? _____Y ____N

If Yes, please provide details including any treatments given (Attach an additional page if needed) :_____

_____

_____

_____

Is there any additional pre-natal or delivery information that might be of assistance to us ?

_____

_____

_____

Developmental / Medical History

1. Please indicate the age at which your client did the following:

- Walked unassisted _____
- Said 1st word intelligible to strangers_____
- Said two - three word phrases_____
- Used sentences regularly_____
- Toilet trained during the day_____
- Dry through the night (6+ months) _____
- Dressed self_____

2. Please indicate if your client is experiencing any of the following :

- Problems with eating _____
- Isolated socially from peers _____
- Problems making friends _____
- Problems keeping friends _____
- Problems controlling temper _____
- Problems sleeping through the night _____
- Trouble waking up _____
- Fatigue / Tiredness during the day _____
- Nightmares _____
- Enuresis (bed wetting) _____
- Fecal hoarding/smearing _____
- problems with authority _____
- Anxiety _____
- Stress _____
- History of abuse _____
- Alcohol or drug abuse _____
- Lack of motivation _____
- School concentration difficulties _____
- Grades dropping or consistently low _____
- Sadness or depression _____

3. List any operation (s), serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions he/she has had._____

_____

_____

_____

4. List all medications he/she is currently taking (give dosage level if possible):

Name	How often	Dosage

5. List any allergies:

Environmental	Food	Medication

6. List any dietary information:

A. Special diet:_____

B. Limited food selection:_____

Does he/she have the ability to use utensils to adequately feed self? _____Y_____N

7. Does he/she have any vision problems? _____Y_____N

8. Does he/she have any hearing problems? _____Y_____N

Physician Information:

Name of clients *referring* physician:_____

Practice Name :_____

Address:_____

Phone Number: _____Fax Number:_____

(Attach and additional page to list information on other Physicians if needed)

Education History:

1. List Schools he/she attended:

Name	System	year (s)	Grade	Special Ed

2. Name (s) of current teacher(s): _____

3. Does his/her teacher have any concerns about him/her (list)? _____

_____

_____

4. What is his/her favorite subject/class?_____

5. What is his/her least preferred subject/class?_____

6. Has he/she ever repeated a grade? Y / N If Yes, What grade(s)?_____

7. Do they have a (Please circle)?

504 plan	**Behavior Intervention Plan**
I.E.P	**Occupational Therapy Evaluation**
Psychological Evaluation	**Physical Therapy Evaluation**
Special Evaluation	**Adaptive Technology Evaluation**
Vinland-3 Date: _____	**SRS-2 Date: _____**
ADOS Date:_____	**Other(s)_____**

8. If he/she has been in special education, how were they served (please circle)?

Consultation	**Resource Classroom**
Collaborative Education	**Team Taught Classes**
Pulled - Out	**Self-Contained classroom**

9. What are his/her extracurricular activities, including sports, clubs, hobbies, lessons, ect.?

_____Football	_____Karate	_____Dance (type)_____
_____Baseball	_____Piano	_____ Music (type)_____
_____Cheerleading	_____Scouts	_____ Gymnastics (type)_____
_____Basketball	_____Soccer	_____ Other(s) _____

10. List any special abilities, skills, strengths he/she has._____

_____

_____

_____

11. Can he/she :

- Sort by Colors _____Y_____N
- Sort By Shapes _____Y_____N
- Match identical objects _____Y_____N
- Identical pictures _____Y_____N
- Similar, but not identical pictures _____Y_____N

12. Can he/she identify letters?

- Lowercase _____all_____some_____ none
- Uppercase _____all _____some_____ none

13. Can he/she identify numbers?

- Single digits (0-9) _____all_____some_____none

14. Can he/she count?

- Can count to 10? _____Y _____N
- Can count to 20? _____Y _____N
- Can count to 20+? _____Y _____N

15. Can he/she count out a number of objects (exp. Give me four pennies)

- Up to 5 objects? _____Y _____N
- Up to 10 objects? _____Y _____N
- 10+ objects? _____Y _____N

16. Can he/she identify double digit numbers ? 10-99 _____ all____ some _____none

17. Can he/she complete simple addition math problems? _____Y _____N

18. Can he/she complete simple subtraction problems? _____Y _____N

Letters

19. Can he/she identify letter sounds? _____all____some _____none

- identify blends(exp. sh, st, cr) _____Y _____N
- Sound out words with blends? _____Y _____N

Reading:

20. Can he/she read simple words(2- 4 letter simple words - cat, dog, sat)?____Y_____N

Read longer words and sight words (there, Just , Jump)? _____Y_____N

Sound out unknown words? _____Y_____N

Read Simple sentences _____Y_____N

Comprehend what he/she is reading (can answer questions about what's been read?)

_____Y _____N

Self Care:

1. Dress him/herself? Y / N _____Independently_____with some assistance

2. Bathe him/herself? Y / N _____Independently_____with some assistance

3. Groom him/herself (brushing teeth, combing hair) ? Y / N

4. _____Independently _____with some assistance

5. Clean after him/herself? Y / N __Does not_____Independently _____when asked

6. Toilet -Trained? Y /N _____Independent_____when taken _____day time

7. __Night time _____diapers/pull-ups

8. Do you have safety concerns regarding his/her activities at home? _____Y_____N

- If yes please explain_____

9. Self-care concerns ? ____Y _____N

- If yes please explain _____

Attending / Engagement

1. Does he/she make eye contact with others?_____ Always_____sometimes _____ rarely
2. Answers or looks when name is called?_____ Always_____sometimes_____rarely
3. Can he/she answer questions when there is background noise, other people, and /or other distraction?_____ Always_____sometimes_____rarely

Auditory Processing

1. Does he/she appear to understand directions and questions?_strength_____challenge
2. Can he/she appropriately play by him/herself? _____Y _____N
3. Does he/she appear to have good memory? _____Y _____N

Auditory Processing Comments: _____

_____

_____

_____

_____

Interests:

List hobbies or interests:

_____

_____

_____

List unusual interest or obsessions: _____

_____

_____

List favorite activities, food/snacks, toys, games(Number 1-10in order of importance to the client): _____

_____

_____

Behavior:

1. Physical Stereotypic Behavior:

- Does he/she flap his/her hands/arms? _____Y _____N
- Does he/she seem to look at his/her fingers in a stereotypic way?_____Y _____N
- Does he/she seem to look out of the side of his/her eyes? _____Y _____N
- Does he/she walk on their toes? _____Y _____N

- Does he/she rock (sit and rock back and fourth)? _____Y _____N

2. Verbal Stereotypic Behavior

- Echolalia-repeats what is said/heard _____intermediate _____Y _____N

_____Sometimes

- Echolalia-delayed-(Will repeat what's been said/heard later)? _____Y _____N
- Self - Talk? _____Y _____N
- Humming to self-Inappropriate ? _____Y _____N
- Screech or Yell inappropriately? _____Y _____N

3. Preservation

- Does he/she get stuck on topic? _____Y _____N
- Get obsessive about specific people? _____Y _____N
- Get obsessive about specific objects? _____Y _____N

4. Transition/ Routines

- Has trouble with sudden change? _____Y _____N
- Has Trouble With changes that they are warned about? _____Y _____N

5. Fears:

- Does he/she fear any specific objects, animals, places, people? _____Y _____N
- If, Yes please_____

_____

6. Tantrums/ Aggression/ Self-Injury:

- Does he/she have tantrums that you feel needs to be addressed? _____Y____N
- Describe behavior: _____

_____

_____

7. What triggers a tantrum ?

- When told “No” (you can’t have that /can’t do that)? _____Y_____N
- When he/she is not getting attention or wants attention? _____Y_____N
- To avoid a non-preferred task ? _____Y_____N
- To escape a non-preferred activity? _____Y_____N
- For no obvious reason? _____Y_____N

8. Does your client react aggressively at times? _____Y _____N

- Describe aggressive behaviors:_____

_____

9. Is this behavior disruptive enough that you feel needs to be addressed? ___Y_____N

10. What triggers aggressive behavior ?

- When told “no” (you can’t have that/ can’t do that)? _____Y_____N
- When he/she is not getting attention or wants attention? _____Y_____N
- To avoid a non-preferred task ? _____Y_____N
- To escape a non-preferred activity? _____Y_____N
- For no obvious reason? _____Y_____N

11. Does he/she engage in self-injurious behavior (hurt him/herself)? _____Y_____N

- Describe self-injurious behavior: _____

_____

_____

12. What triggers self-injurious behavior?

- When told “no” (you can’t have that/ can’t do that)? _____Y_____N
- When he/she is not getting attention or wants attention? _____Y_____N
- To avoid a non-preferred task ? _____Y_____N
- To escape a non-preferred activity? _____Y_____N
- For no obvious reason? _____Y_____N

- Behavior Comments:_____

_____

_____

Sensory Issues:

1. Does he/she have sensitivity to (if Yes, explain in comments):

- Sound? _____Y _____N
- Light ? _____Y _____N
- Touch? _____Y _____N
- Texture? _____Y _____N
- Food ? _____Y _____N
- Sensory Comments:_____

_____

_____

Imitation of Movements and Speech/Language:

1. Can he/she imitate movements when they are demonstrated (clap hands, touch headphone someone else is doing the same and is asked to “do this or clap hands”)?___Y_____N
2. Can imitate motions that goes along with a song? _____Y_____N
3. Can imitate a word or words when told to “say _____”? _____Y_____N
4. Does he/she repeat what he/she has heard other people or TV characters say?_____Y___N

- If Yes, please explain:_____

_____

Does he/she use communication system such as PECS, sign, augmentative device, etc.?

_____Y_____N

5. Does he/she appear to understand language? _____ not at all _____ a little _____ this is a strength
6. Does he/she use words in isolation? _____Y_____N
7. Does he/she identify objects when asked? _____Y_____N
8. Can he/she identify actions (“ Where is the boy who is running “ When shown pictures of kids playing)? _____Y_____N
9. Can he/she identify describing words (red vs blue, Big vs little)? ____ not at all ____ a little _____ this is a strength
10. Can he/she understand simple sentences (“drink your milk”) ? _____Y_____N
11. Can understand more complex sentences (“go get your red shoes,” “give me the one that is not wet”)? _____Y_____N
12. Can he/she follow directions? ____Y____N - ____ one step ___ two steps ____ three steps
13. Can he/she follow directions with delay(“ after your finish eating , go get your shoes”)? _____Y_____N
14. Does he/she use the following when speaking?

- Nouns (people, places, and things)?_____sometimes_____always_____never
- Verbs? _____sometimes_____always_____ never
- Adjectives (describing words)?_____sometimes_____always_____never
- Prepositions (in, out, on etc.)?_____sometimes_____always_____never
- Pronouns (I, You, She, he) ?_____sometimes_____always_____never

Across the Board Therapy Group LLC
Policies

Attendance.
At Across the Board Therapy Group, scheduled appointments are a bond between our therapists and our patients. This is our opportunity to provide the highest standard of care to each patient. To help us honor our commitment to your care, we ask all families to follow a few simple guidelines:

1. Arrive for your appointment on time
2. Provide at least a twenty four (24) hour notice for cancellations
3. Limit number of cancellations
4. Honor our bond

We realize that emergencies happen and schedules change. However, appointments that ware habitually missed, cancelled, or changed will result in one of the following actions:

1. Loss of your regular appointment time
2. Reduction in number of weekly appointment
3. Discharge from this facility as a result of poor attendance

If we feel attendance patterns are habitually not meeting our expectations, we reserve the right to initiate the able procedures at our discretion. No show appointments will result in a $25.00 charge. That charge is not covered by insurance and will be the responsibility of the guarantor on the account. Failure to pay the charge will result in discharge from this facility. Cancelations at or during your scheduled therapy session are considered a no show.

Illness.
If your child is sick please do not bring him/her to therapy until they are sufficiently well. Some of our patients may be medically fragile, therefore, do not bring sick siblings in the Clinic either.

Payment.
Unless other arrangements have been made, payment is due at the time of the service. Medical records will not be released if there is an outstanding balance.

Clinic.
Parents are to remain at the Clinic during their child's services. If it is necessary to leave, the parents must provide a phone number where they can be reached. Typically pediatric sessions are every 30 minutes, therefore, parents are asked to be present five (5) minutes prior to the end of the session to discuss their child's progress and home activities.

Name of Patient:_____
Signature of Parent:_____
Date:_____

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative:_____
Signature of Legal Representative:_____
Date:_____

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CONSENT TO TREATMENT

I hereby consent to ACROSS THE BOARD THERAPY, LLC, to furnish therapy services to_____ as prescribed by the physician. I hereby authorize payment directly to ACROSS THE BOARD THERAPY, LLC, of the individual or group insurance benefits specified and otherwise payable to me. I understand I am fully responsible to ACROSS THE BOARD THERAPY, LLC, for all charges not paid by my insurance provider. ACROSS THE BOARD THERAPY, LLC, is authorized to release to said insurance companies, to Transworld Systems, Inc. any/all information listed above and/or medical records.

Name of Patient:_____

Signature of Parent:_____

Date:_____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative:_____

Signature of Legal Representative:_____

Date:_____

Name of Witness:_____

Signature of Witness:_____

CONSENT TO RELEASE INFORMATION

Patient's Name:	
Patient's Date of Birth:	
Patient's Address:	
Patient's Biological Parents' Names or Legal Guardian:	

I authorize Across The Board Therapy, LLC, to release and/or obtain information about the above patient from:

Patient's Primary Care Physician:	Address:	Telephone:	Facsimile:
Insurance Company:	Policy Number:	Address:	Telephone:
School District:	Address:	Telephone:	Facsimile:
Teacher:	Address:	Telephone:	Facsimile:
Other:	Address:	Telephone:	Facsimile:

Signature of Parent:_____
Date:_____

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative:_____
Signature of Legal Representative:_____
Date:_____
Name of Witness:_____
Signature of Witness:_____

Notice of Privacy Practices
How Your Medical Information Is Used

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

This Notice applies to ACROSS THE BOARD THERAPY GROUP, LLC ("ACROSS THE BOARD"). ACROSS THE BOARD will use and distribute this Notice as its Notice of Privacy Practices and follow the information practices described in this Notice when using or disclosing records and information. It will share your health information as allowed and necessary, to carry out treatment, payment, or health care operations as described in this Notice.

Understanding Your Health Information

Each time you visit a hospital, clinic, physician, or other health care provider, a record of your visit is made. Typically, this health record contains your medical history, symptoms, examination and test results, diagnosis, treatment, care plan, insurance, billing, and employment information. This health information, often referred to as your health record, serves as a basis for planning your care and treatment and is a vital means of communication among the many health professionals who contribute to your health care. Your health information is also used by insurance companies and other third-party payers to verify the appropriateness of billed services.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your health information during your lifetime and for years following your death.
- Provide you with an additional current copy of our Notice upon request.
- Abide by the terms of our current Notice.
- Notify you following a breach of unsecured protected health information in the event you are affected.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

Uses And Disclosures Without Your Written Authorization

We may use and disclose your health information without your written authorization for Treatment, Payment and Health Care Operations

We will use and disclose your health information for treatment purposes

For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment. Health care team members will communicate with one another personally and through the health record to coordinate care provided. We will also provide your physician or subsequent health care provider with copies of various reports that should assist him or her in treating you in the future.

We will use and disclose your health information for payment purposes

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the

bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may disclose health information about you to other qualified parties for their payment purposes. For example, if you are brought in by ambulance, we may disclose your health information to the ambulance provider for its billing purposes.

We will use and disclose your health information for health care operations

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of health care we provide. In some cases, we will furnish your health information to other qualified parties for their health care operations. The ambulance company, for example, may want information regarding your condition to help them know whether they have done an effective job of stabilizing your condition.

Health Information Exchange

We may make your protected health information available electronically through an information exchange service to other health care providers, health plans and health care clearinghouses that request your information. Participation in information exchange services also lets us see their information about you.

Teaching

Residents, fellows, and students in medicine, therapy, allied health and graduate studies, may be assisting with your care under the supervision of a licensed health care provider as a part of their professional health care training program.

Other Uses and Disclosures of your health information Without your Written Authorization

Notification

We may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location and general condition.

Communication With Family and Others

We may disclose relevant health information to a family member, friend, or other person involved in your care. We will only disclose this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf.

Directory

Unless you notify us that you object, or we are otherwise prohibited by law, we may use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy, and, except for religious affiliation, to other people who ask for you by name.

Business Associates

There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform such services. However, we require the business associate to appropriately safeguard your information.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives

We may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising

We may use and disclose your health information to our business associates and affiliated foundations for fundraising purposes. We may contact you in an effort to raise money for clinical programs, research and education. If you do not want us to contact you for fundraising efforts, you must notify ACROSS THE BOARD immediately.

Public Health

We may disclose health information about you for public health activities. These activities may include disclosures:

- To a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability;
- To appropriate authorities authorized to receive reports of abuse and neglect;
- To FDA-regulated entities for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products; or
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- With parent or guardian permission, to send evidence of required immunizations to a school.

Workers' Compensation

We may disclose health information to the extent authorized and necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Correctional Institutions

If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose to the correctional institution, its agents or the law enforcement official your health information necessary for your health or the health and safety of other individuals.

Law Enforcement

We may disclose your health information for law enforcement purposes:

- At the request of a law enforcement official and in response to a subpoena, court order, investigative demand or other lawful process;
- If we believe it is evidence of criminal conduct occurring on our premises;
- If you are a victim of crime and we obtain your agreement, or under certain circumstances, if we are unable to obtain your agreement;
- To identify or locate a suspect, fugitive, material witness or missing person;
- To alert authorities that a death may be the result of criminal conduct;
- To report a crime, the location of the crime or victim, or the identity, description or location of the person who committed the crime.

Health Oversight Activities

We may disclose health information for health oversight activities authorized by law. For example, oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Threats to Health or Safety

Under certain circumstances, we may use or disclose your health information if we believe it is necessary to avert or lessen a serious threat to health and safety and is to a person reasonably able to prevent or lessen the threat or is necessary for law enforcement authorities to identify or apprehend an individual involved in a crime.

Specialized Government Functions

We may disclose your information for national security and intelligence activities authorized by law, for protective services of the president; or if you are a military member, to the military under limited circumstances.

As Required by Law

We will use or disclose your health information as required by federal, State or local law.

Lawsuits and Administrative Proceedings

We may release your health information in response to a court or administrative order. We may also provide your information in response to a subpoena or other discovery request, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Funeral Directors, Medical Examiners, and Coroners

We may disclose your health information to funeral directors, medical examiners, and coroners consistent with applicable law to carry out their duties.

Organ Procurement Organizations
Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
Incidental Uses and Disclosures
There are certain incidental uses or disclosures of your health information that occur while we are providing services to you or conducting our business. For example, after surgery the nurse or doctor may need to use your name to identify family members that may be waiting for you in a waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

Uses And Disclosures That Require Your Written Authorization

The following uses and disclosures will only be made with your written authorization:
• Uses and disclosures not listed above as permitted without your written authorization;
• most uses and disclosures of psychotherapy notes;
• uses and disclosures for our marketing purposes; and
• disclosures that constitute a sale of your health information.
Your authorization may be revoked in writing at any time except with respect to any actions we have taken in reliance on it.

Your Health Information Rights

You have the following rights regarding your health information:
Right to Inspect and Copy
You may request to look at your medical and billing records and obtain a copy. You must submit your medical records request to the Health Information Management Department. Contact the office listed on your billing statement to request a copy of your billing record. If you ask for a copy of your records, we may charge you a copying fee plus postage. If we maintain an electronic health record about you, you have the right to request your copy in electronic format.
Right to Request Amendment
You may request that your health information be amended if you feel that the information is not correct. Your request must be in writing and provide rationale for the amendment. Please send your request to the Health Information Management Department. We may deny your request, and will notify you of our decision in writing.
Right to an Accounting of Disclosures
You may request an accounting of certain disclosures of your health information showing with whom your health information has been shared (does not apply to disclosures to you, with your authorization, for treatment, payment or health care operations, and in certain other cases).To request an accounting of disclosures, you must send a written request to Across the Board. Your request must state a time period that may not be longer than six years.

Right to Request Restrictions
You may request restrictions on how your health information is used for treatment, payment or health care operations or disclosed to certain family members or others who are involved in your care. We may deny your request with one exception. If we agree to a voluntary restriction, the restriction may be lifted if use of the information is necessary to provide emergency treatment. We are required to agree to your request that we not disclose certain health information to your health plan for payment or health care operations purposes, if you pay in full for all expenses related to that service prior to your request and the disclosure is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of your records to your health plan, we will assume you have withdrawn your request for restriction. To request a restriction, you must send a written request to Across the Board, specifying what information you wish to restrict and to whom the restriction applies. You will receive a written response to your request.

Right to Request Private Communications
You may request that we communicate with you in a certain way in a certain location. You must make your request in writing to the patient registration staff and explain how or where you wish to be contacted.

Right to a Paper Copy of this Notice
You may request an additional paper copy of this Notice at any time.

Complaints

You may complain to us or to the Secretary of Health and Humana Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against your for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask us to explain. Signature below confirms acknowledgment of our Privacy Practices

We reserve the right to change this Notice as our privacy practices change and to make the new provisions effective for all health information we maintain.

Name of Patient:_____

Signature of Patient:_____

Date:_____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative:_____

Signature of Legal Representative:_____

Date:_____

Name of Witness:_____

Signature of Witness:_____

Across the Board THERAPY GROUP
SPEECH · BEHAVIORAL/ABA · OCCUPATIONAL · PHYSICAL

HIPAA RELEASE OF INFORMATION
AUTHORIZATION FORM

I, _____hereby authorize ACROSS THE BOARD THERAPY GROUP, LLC, and its affiliates, its employees and agents (collectively "ACROSS THE BOARD"), to release to _____ my personal health information maintained by ACROSS THE BOARD (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative's signature below and shall expire on the date my coverage ends with ACROSS THE BOARD.

I understand that I have a right to revoke this authorization by providing written notice to ACROSS THE BOARD. However, this authorization may not be revoked if ACROSS THE BOARD, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient:_____
Signature of Patient:_____
Date:_____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative:_____
Signature of Legal Representative:_____
Date:_____
Name of Witness: _____
Signature of Witness:_____

Across the Board THERAPY GROUP

SPEECH • BEHAVIORAL/ABA • OCCUPATIONAL • PHYSICAL

AUTHORIZATION
TO PICK UP A CHILD FROM
ACROSS THE BOARD THERAPY GROUP

Name of
Child(ren):_____

I hereby inform Across the Board Therapy Group that the people listed below are authorized to pick up the above named child(ren) at anytime. Accordingly, Across the Board Therapy Group is hereby instructed to release my child(ren) into the care of the following people whenever they come to Across the Board Therapy Group.

AUTHORIZED PICK-UP PERSON:

Name:	Relationship to Child:	Phone Number:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

I understand that:

- Parents/guardians must inform Across the Board Therapy Group (call, leave a note at drop off) of the name of the person who is picking up their child on any day when they themselves are not.
- The "Authorized Pick-Up Person" **must be at least 18 years old** and may be asked to provide a photo ID to the staff.
- This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.
- Children will not be released to persons who fail to provide acceptable identification upon request.

Authorized by:

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date