Anticipated Start Date _____

Application and Intake Packet for Program Enrollment

Name of Child: _____
(First) (Middle) (Last)

Date of Birth: _____ Age: _____Gender: Male / Female

Ethnicity: Caucasian / African American / Hispanic / Asian / Other _____

School Last Attended by Applicant

Name: _____
Address: _____
Phone: _____
Email: _____
Does your child have an established IEP? Y / N
If yes, will you provide us a copy or sign consent for us to obtain a copy? Y / N

Applicant's Parent/Guardian Contact Information

Parent / Legal Guardian _____
Address: _____
City: _____State/Zip: _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Cell Phone: (_____) _____ Email: _____
Employer: _____Title:_____

Parent / Legal Guardian _____
Address: _____
City: _____State/Zip: _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Cell Phone: (_____) _____ Email: _____
Employer: _____Title:_____

What other parent/guardian are involved in this child's life? _____

Applicant's Siblings

Name: _____ Age: ____ Gender: _____
Name: _____ Age: ____ Gender: _____
Name: _____ Age: ____ Gender: _____
Name: _____ Age: ____ Gender: _____
Name: _____ Age: ____ Gender: _____

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Consultant(s) (i.e. SLPs, OTs, etc.) or Other Organization(s) who have worked with Applicant Include Primary Diagnostic Information

Primary diagnosis: _____ Secondary Diagnosis_____
Age at Diagnosis: _____ Organization that Diagnosed: _____
Professional who made diagnosis: _____
Please list any allergies or other medical concerns: _____
Please list current special diets: _____
Please list any biological interventions:
Intervention: _____

Date Started: _____

Date Ended: _____

Medication:	Dosage:	Frequency of Administration	Date Started

Medical Providers

Name: _____
Address: _____
Phone: _____
Email: _____

Name: _____
Address: _____
Phone: _____
Email: _____

Name: _____
Address: _____
Phone: _____
Email: _____

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Psychological Testing

Has your child had Psychological Testing or completed in the past 12 months? Y / N
If the answer is yes, did this testing include a Vineland, Academic Achievement, or IQ assessment? Y / N or UNSURE _____
If the answer is yes, you will be asked to provide copies of these records that would be relevant for this assessment and for the purpose of having records on file for insurance and related billing. It is necessary to have relevant assessments on file before we schedule your child for his/her initial assessment. Thank you for your cooperation!

Verbal Behavior Testing / Applied Behavioral Analysis

Has an ABLLS-R and/or VB-MAPP been completed? Y / N or UNSURE _____
If yes, what was the date of completion? _____
Have you ever been to a presentation regarding Verbal Behavior methodology?
Y / N
If yes, please list the presenter, location of presentation and date of presentation:
_____
Does your child currently have a home program? Y / N
If yes, please describe the type of program, the frequency of sessions, length of sessions and individuals involved in the sessions.
_____
Please describe your child's current functional communication system (PECS, signs, vocal).
_____
Please describe your child's current cooperation in teaching situations.
What reinforcers are used? _____
How many responses are required before reinforcement is delivered? _____
Does teaching occur at a table or in the natural environment? _____
Please describe your child's current receptive repertoire (i.e. responding to name, following 1 and 2 step directions, selecting items when asked).
_____

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

MEDICAL/ EMERGENCY CONTACT

Doctor Information

Doctor's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Medical Information

Medical Diagnosis: _____

Diet Specifications: _____

Food and Drug Allergies: _____

_____

Medications: _____

_____

Please check if your child has a history of:

- ☐ Seizures
- ☐ Staring episodes
- ☐ Swallowing difficulties
- ☐ Sleep difficulties
- ☐ Headaches
- ☐ Bowel problems
- ☐ Ear infections
- ☐ Chewing problems
- ☐ Bladder problems
- ☐ Drooling
- ☐ Motor/vocal tics
- ☐ Hearing problems
  Previous hearing test results:
  - o Normal
  - o Abnormal
- ☐ Vision problems
  Previous vision test results:
  - o Normal
  - o Abnormal

Medical History (Frequency of those checked above, if your child was sent to the hospital for anything, if your child has concurring issues, or if your child takes medication for any problem:

_____

_____

_____

Emergency Contact

In case of emergency, please contact:

Name: _____ Relationship to child: _____

Phone: _____

Name: _____ Relationship to child: _____

Phone: _____

I give the Rose Street Spectrum Program permission to administer First Aid/CPR on my child if an emergency situation arises.

Parent/Guardian Signature:_____ Date: _____

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

BIRTH HISTORY

Was this child adopted? ___ Yes ___ No
Age when taken home: _____ Length of pregnancy: _____ weeks Birth weight: _____lbs.
Was there trauma associated with the birth of the child? ___Yes ___No
If yes, please explain here:
_____
_____
_____
_____
_____

FAMILY HISTORY

Biological Mother

Education:
___Did not Graduate ___GED ___High School ___Some College
___2 year university ___ 4 year university ___Advanced
Mother's Occupation: _____

Biological Father

___Did not Graduate ___GED ___High School ___Some College
___2 year university ___ 4 year university ___Advanced
Father's Occupation: _____

Parent's Marital Status/Visitation

Child's Parents Are: ___Never Married ___Separated ___Divorced ___Married to Each Other
If separated or divorced, how often does the child see the non-custodial parent?
___Regularly ___Sometimes ___Rarely ___Never

Siblings

Number of siblings in the home: _____ Are they ___ older ___younger ___male___female
Describe their relationship:
Do any biological siblings have learning, speech, behavior, or other problems? ___Yes ___No
If yes, please describe: _____

Family History

Please indicate if the mother, father, or anyone on either side of the family has a history of:

- ☐ Mental Retardation
- ☐ Genetic Syndromes
- ☐ Autism/PDD-NOS
- ☐ Asperger Syndrome
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Seizures
- ☐ Attention Problems
- ☐ Depression
- ☐ Drug Abuse
- ☐ Alcoholism
- ☐ Speech/Language Disorders
- ☐ Learning Disabilities/Dyslexia
- ☐ Neurological Problems

Stressors

- ☐ Parent Separation/Divorce
- ☐ Moves to Different Homes
- ☐ Loss/Death of Friend or Pet
- ☐ Family Financial Difficulties
- ☐ Moves to Different Schools
- ☐ Loss/Death of Family Member
- ☐ Social Problems or Bullying
- ☐ Multiple Absences/Tardies

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Please check any of the following behaviors that your child displays:

- ☐ Hyperactivity
- ☐ Self-injurious behaviors
- ☐ Echolalia (vocal repetition of others)
- ☐ Anxiety (control/transition/coping difficulties)
- ☐ Aggressive behaviors (toward others or objects)
- ☐ Self-stimulatory behaviors (repetitive movements and/or sounds)

Does your child…	Never	Seldom	Occasionally	Often	Always
Use gestures (bye-bye, pointing, etc.)	0	1	2	3	4
Babble	0	1	2	3	4
Use single words	0	1	2	3	4
Use single words to request	0	1	2	3	4
Use phrases	0	1	2	3	4
Use phrases to request	0	1	2	3	4
Ask questions	0	1	2	3	4
Play with toys appropriately (independently)	0	1	2	3	4
Plays interactively w/ siblings	0	1	2	3	4
Plays interactively w/peers	0	1	2	3	4

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Brief Social Skills Checklist

The following checklist is an abbreviated version of the one to be conducted
This portion should be completed by the parent(s) and should be answered in accordance with social behaviors perceived by the parent(s) on a day to day basis.

1. Does your child look and/or come when their name is called? Y / N
2. Does your child imitate 1 step motor tasks? Y / N
3. Does your child sit and attend to simple tasks? Y / N
4. Will your child sit next to peers? Y / N
5. Will your child pass an item to a peer? Y / N
6. Does your child say “Hi” in response to greetings? Y / N
7. Does your child share toys? Y / N
8. Does your child end play appropriately (without problem behavior)? Y / N
9. Can your child sit and play simple games with adults directing? Y / N
10. Is your child able to tolerate new demands/tasks with support? Y / N
11. Does your child ask for help when engaged in a difficult task? Y / N
12. Does your child state their wants/needs 30+ times per day? Y / N
13. Does your child identify others by name? Y / N
14. Can your child answer 1-3 social questions i.e.name, age, pet names? Y / N
15. Does your child answer yes/no questions appropriately? Y / N
16. Does your child ask for information: “What is that?” “Where is it?” Y / N
17. Does your child ask for attention i.e. “Watch me” “Look at me?” Y / N
18. Does your child offer information about his/her school day? Y / N
19. Does your child label their emotions appropriately? Y / N
20. Does your child guess others imitations of emotions? Y / N
21. Does your child understand the concept: First, Then? Y / N
22. Does your child play with the same peer(s) across several days and activities? Y / N
23. Can your child sit and listen to group stories? Y / N
24. Does your child show others objects with intent to share? Y / N
25. Does your child follow instructions to go get items/supplies? Y / N
26. Does your child greet/wave “Hi” with person’s name? Y / N
27. Can your child joint play/build/work on simple projects together, with peer? Y / N
28. Does your child ask 1-3 peers to join in their play? Y / N
29. Does your child sustain play for up to 20 min. with peers? Y / N
30. Does your child tolerate other’s choice in play? Y / N
31. Does your child tolerate new tasks willingly? Y / N
32. Is your child able to tolerate a delay in reinforcement: 1-2 hours? Y / N
33. Does your child raise his/her hand and wait to talk? Y / N
34. Does your child accept “no” for an answer without problem behavior? Y / N
35. Does your child recognize his/her own space (doesn’t touch others)? Y / N
36. Does your child answer question of non-interest (w/adult/peers)? Y / N
37. Does/can your child tell simple jokes? Y / N
38. Does your child respect the personal space of family, friends, and strangers? Y / N
39. Does your child retell events of that day/yesterday? Y / N
40. Does your child have the ability to use self-talk as a reminder of what to do? Y / N
41. Does your child give others compliments? Y / N
42. Does your child invite friends over for play dates? Y / N

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Rose Street Spectrum's Client Policies
Annotated Version 11.1 2013

Please keep the policies so you may refer back to them.

Open Door Policy
Observation of ABA therapy will be made available in the open gym and in your child's selected 1:1 training area, Please take a moment to check in so that we may transition any child whose parent has not authorized observation out of the area to ensure that we protect their rights and confidentiality. During these times, parents can observe their child's progress and take notes on therapeutic procedures/programs. You are welcome to observe your child's entire session or observe only a part of the session. A waiting room is available when you are no longer observing your child or you may leave and return to pick your child up when his/her session is finished. Please plan to make arrangements for your other children when you are observing. It is distracting to the other children learning to have siblings in the therapy room. Please, do not leave children of any age unattended in the waiting room. Cell phones must be put away and turned to silent while in the therapy room. Observation of social groups is by appointment only. Some of our children are sensitive to major changes in their environment or schedule, such as a new adult in the room, and such a change may need to be introduced rather than spontaneous. Thank you for understanding. Please note that our open door policy remains as a time for you to observe your child and take notes. Unless you have set up an appointment for a session with your child's Case Manager, please do not ask the therapist working with your child questions during this time. If you have a question about the programming or procedure please wait and email your child's Case Manager and he/she will be able to help you.

Late Policy
Therapy sessions have a specified start and end time. We cannot accommodate children left past their scheduled therapy sessions. If you are late picking up your child, you will be charged one dollar ($1) for every minute you are late. The charge will be added to your next invoice regardless of your insurance. Additionally, it is important that your child be on time for their session or group. It is disruptive for children to arrive late and they miss out of their therapy time. There will be no proration or make-ups for late arrivals.

Required Parent Involvement
Parent involvement is essential to the success of our students. All parents are required to attend at least one (1) meeting each quarter with their child's case manager for a minimum of sixty (60) minutes. This will give you the opportunity to be informed about the programs your child has worked on the progress made and any concerns you may have.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Absence Policy

If you have alternative plans, in which you will not be attending the BWF during your scheduled sessions you must provide notice 30 days in advance in order for your account to be prorated. For example, if you are aware of specific observed holidays, vacation plans, or doctors' appointments, please let us know 30 days in advance and you will not be charged for those missed days. If you wish to reduce your scheduled number of hours or discontinue services, those changes must be made 30 days in advance in order to prorate your account. If you reduce the schedule number of hours or cancel services without 30 days' notice, you will be financially responsible for the final 30 days of services, no exceptions. If you wish to increase your number of hours, those changes can be made at any time and those charges will be added to the following month's bill (note, we will always do our best to accommodate any additional sessions).

Sick Policy

If your child is sick, you must call the office @940-228-5297 and leave a message or email wfspectrum@gmail.com preferably at least 24 hours in advance in order for us to notify staff, but at least within 8 hours to not incur charges on your account. Otherwise you may be subject to charges, unless not otherwise authorized in your contract. If we do not hear from you will be considered a no show and will incur charges according to policy. Cases of extended illness will be dealt with on a case by case basis through communication with administration.

Children must be fever, diarrhea, and vomit free for 24 hours without the use of fever reducing medication before returning to the office after being ill. If your child becomes ill while at our office, we will call you to pick him/her up immediately.

Medications and Supplements Policy

We are unable to administer medications/supplements to any client. Parents may issue medications/ supplements to your child, but the medication/supplements cannot remain with the staff. Parents must keep medication with them at all times. Medications or supplements cannot be put into a child's food or drinks. If you have any questions regarding this policy, please speak with Rachel.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

SICK CANCELLATION POLICY

Due to the medical needs of our clients, we require that parents/caregivers cancel therapy sessions for the following reasons:

- Fever at or above 100°F
- Vomiting
- Sinus infections/colds with yellow, green mucous
- Conjunctivitis (pink eye)
- Lice
- Strep Throat
- Chicken Pox, Measles, Mumps, RSV, Rubella, Mononucleosis
- Flu-like symptoms
- Viral infections, rashes, or any other contagious illness

Your child may begin receiving services after an illness within the below listed time periods:

- 24 hours – Must be symptom-free and receiving the necessary medications for: vomiting, fever, sinus infections, and colds.
- 48 hours – After receiving medical treatment with antibiotics for: Strep throat and conjunctivitis.
- 72 hours – After receiving medication treatment and having no live lice; also, following maintenance treatments as indicated on product label.
- Physician's Release – Must obtain after chicken pox, measles, mumps, RSV, rubella, and mononucleosis. (If for any reason your child is admitted to the hospital, you must provide a release from the Physician stating that it is okay to resume therapy, and/or resume limited therapy; before services can be continued).

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Billing Policy

Billing statements will be sent to you monthly, and reminders will be sent home with your child as well mailed to your residence if you have an overdue balance so arrangements can be bring your account charges current. The charges will reflect your agreement and any adjustments reflected to your account might reflect our contracts made with your insurance provider. You will be responsible for any amounts that are not paid my your insurance providers or any amounts agreed as detailed in your contract for service. We will notify you each month about your schedule and will allow you to make plans in advance to make modifications to your child's schedule each month in advance, in order for us to staff accordingly to your child's therapeutic plan that you have agreed to. You are responsible for ensuring that you notify us in advance if you cannot attend an appointment to avoid any late fees or service charges.

***Please note, the Rose Street Spectrum Facility may close unexpectedly due to inclement weather or other emergencies in order to provide the safest environment for your children. You will not be charged for these days, but must be prepared to make other arrangements for your children in the event that these unexpected emergencies occur.*

Authorization to Release Information and Submission of Claims

I hereby authorize Rose Street Spectrum to submit claims for services covered under my insurance plan, on my behalf. By checking and initializing the box below, I give Rose Street Spectrum the authorization to bill said insurance directly and disclose any documents necessary to the insurance company for continued services.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Payment Policy

Rose Street Spectrum will require a deposit for:

- Self-pay clients that are equal to the amount of two week's invoice. These deposits will be deposited into your account and can be used for two weeks of services. If payment is not made by the 2nd week of service, the deposit will be used for those service and services will be suspended. If that occurs, you will be responsible for providing another deposit before the child can resume therapy.
- Insurance Funded Clients that is equal to the amount of one month's co-pay. These deposits will be deposited into your account and can be used for the last month of service. If payment is not made by the end of the month, the deposit will be used for that month of service and services will be suspended. If that occurs, you will be responsible for providing another deposit before the child can resume therapy.

Your deposit may also be used to pay your bill in the event of a returned check. A deposit can be made in the form of a cashier's check, cash, money order, check, or credit card. Any credit cards used for a deposit will need to be made at the Main Campus (1800 Rose Street, Wichita Falls, TX, please See Deborah or Yen).Additionally, you will be responsible for paying any returned check fees (currently our bank charges $35).

Rates

Quality of service is of the utmost importance to the staff at Rose Street Spectrum. Our team of Case Managers and Assistant Case Managers includes individuals who are certified and those who are steadily working toward towards their certification by the Behavior Analysis Certification Board. The standard billing rate for each level of therapist employed by Rose Street Spectrum was set in order to provide quality services at an affordable rate.

When you begin your services here with Rose Street Spectrum will have you sign a commitment package that will outline your child's recommended package of care for optimum level of service. At this time your child will be assigned a team skilled, trained, and motivated staff that is motivated and committed to your child's care. To ensure that we meet the basic practices of standard care and we make every effort to maintain a enough staff to serve your child, your commitment will be required in order to maintain your child's scheduled session times for optimum care.

Standard rates, packaged rates, and reduced rates are can be made available for those who would like to contract with Rose Street Spectrum who are non-insured or under-insured, who qualify for those rates, and who pay for services out of pocket. These rates are set by the directors as a way to assist families in accessing the necessary therapy for their child.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Agreement for Service

BACKGROUND:

A. The Customer is of the opinion that the Service Provider has the necessary qualifications, experience and abilities to provide services to the Customer.

B. The Service Provider is agreeable to providing such services to the Customer, on the terms and conditions as set out in this Agreement.

IN CONSIDERATION OF the matters described above and of the mutual benefits and obligations set forth in this Agreement, the receipt and sufficiency of which consideration is hereby acknowledged, the parties to this Agreement agree as follows:

Services Provided

The Customer hereby agrees to engage the Service Provider to provide the Customer with services consisting of Program Consultation, and the Service Provider hereby agrees to provide such Services to the Customer. Services are limited to the scope of knowledge possessed by a BCBA/BCABA and Tri-Care certified Behavior Interventionists and anything outside that scope of knowledge will be referred to the appropriate individual.

Term of Agreement

The term of this Agreement will begin on the date of this Agreement and will remain in full force and effect until the completion of the Services, subject to earlier termination as provided in this Agreement, with the said term being capable of extension by mutual written agreement of the parties.

Performance

The parties agree to do everything necessary to ensure that the terms of this Agreement take effect.

Compensation

For the services rendered by the Service Provider as required by this Agreement, the Customer will pay to the Service Provider compensation based upon the agreed upon hourly wage. If the Customer's services are covered through the Tricare/Echo program, the Customer gives the Service Provider permission to invoice Tricare/Echo directly for services rendered.

This compensation will be payable upon completion of the agreed to services.

The Customer is entitled to deduct from the Service Provider's compensation any applicable deductions and remittances as required by law.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Confidentiality

The Service Provider agrees that they will not disclose, divulge, reveal, report or use, for any purpose, any confidential information with respect to the business of the Customer, which the Service Provider has obtained, except as may be necessary or desirable to further the business interests of the Customer. This obligation will survive indefinitely upon termination of this Agreement. SEE PRIVACY POLICY.

Return of Property

Upon the expiry or termination of this Agreement, the Service Provider will return to the Customer any property, documentation, records, or confidential information which is the property of the Customer.

Assignment

The Service Provider will not voluntarily or by operation of law assign or otherwise transfer its obligations under this Agreement without the prior written consent of the Customer.

Capacity/Independent Contractor

It is expressly agreed that the Service Provider is acting as an independent contractor and not as an employee in providing the Services under this Agreement. The Service Provider and the Customer acknowledge that this Agreement does not create a partnership or joint venture between them, and is exclusively a contract for service.

Modification of Agreement

Any amendment or modification of this Agreement or additional obligation assumed by either party in connection with this Agreement will only be binding if evidenced in writing signed by each party or an authorized representative of each party.

Costs and Legal Expenses

In the event that legal action is brought to enforce or interpret any term of this Agreement, the prevailing party will be entitled to recover, in addition to any other damages or award, all reasonable legal costs and fees associated with the action.

Time of the Essence

Time is of the essence in this Agreement. No extension or variation of this Agreement will operate as a waiver of this provision.

Entire Agreement

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

It is agreed that there is no representation, warranty, collateral agreement or condition affecting this Agreement except as expressly provided in this Agreement.

Limitation of Liability

It is understood and agreed that the Service Provider will have no liability to the Customer or any other party for any loss or damage (whether direct, indirect, or consequential) which may arise from the provision of the Services.

Gender

Words in the singular mean and include the plural and vice versa. Words in the masculine mean and include the feminine and vice versa.

Governing Law

It is the intention of the parties to this Agreement that this Agreement and the performance under this Agreement, and all suits and special proceedings under this Agreement, be construed in accordance with and governed, to the exclusion of the law of any other forum, by the laws of the State of Texas, without regard to the jurisdiction in which any action or special proceeding may be instituted.

Severability

In the event that any of the provisions of this Agreement are held to be invalid or unenforceable in whole or in part, all other provisions will nevertheless continue to be valid and enforceable with the invalid or unenforceable parts severed from the remainder of this Agreement.

Waiver

The waiver by either party of a breach, default, delay or omission of any of the provisions of this Agreement by the other party will not be construed as a waiver of any subsequent breach of the same or other provisions.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

As a client or applicant for services of Rose Street Spectrum we may use or disclose personal related information about you in the following ways:

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment and written consent is given by you directly.

- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding treatment, appointments, or any other program related information that may be of interest to you.
- 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.
- You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.
- You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purpose. Such requests are not automatic and require the agreement of this office.
- We are permitted and may be required to use or disclose your personal information without your authorization in these following circumstances:
- If we are ordered by our courts or another appropriate agency.
- You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected personal information, other than as outlined above, will only be made upon your written authorization. If you provide an authorized for release of information you have the right to revoke that authorization at a later date.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

- Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

- We normally provide information about your care to you in person at the time you receive services from us. We may also mail information to you regarding your services or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form please advise us in writing as to your preferences.

- You have the right to inspect and/or copy your client information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Request to inspect, copy or amend your client related information should be provided to us in writing.

- We are required by state and federal law to maintain the privacy of your client file and the protected confidential information therein. We are also required to provide you with this notice of our privacy practices with respect to your personal information. We are further required by law to abide by the terms of this of this notice while it is in effect.

- We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Deborah Drummond – ddrummond@rosestreet.org.

- If you would like further information about our privacy policies and practices please contact: ddrummond@rosestreet.org. You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of Jan 1, 2013. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

PHOTO/VIDEOTAPE RELEASE AND CONSENT FORM

The Rose Street Spectrum program utilizes a variety of different digital devices to monitor your child's progress (video, audio, and photograph). The products of these devices maintain confidential standards and are not released without the explicit permission of the parent/guardian. By signing the below consent form, you are granting Rose Street Spectrum exclusive rights and use of these products for training, professional, and advertising purposes.

In connection with my child's participation at the Rose Street Spectrum program, I hereby authorize and give my consent for Rose Street Spectrum program to use their collection of digital products (video, audio, and photograph) of my child. This consent grants the Rose Street Spectrum program exclusive rights of these products without payment or other consideration made to me. These digital products may be printed in newspapers, magazines, websites (private and social), commercials and other forms for advertising, training, or professional purposes. I agree that these photos are the property of Rose Street Spectrum program and may be used at any time until I withdraw my consent in writing.

I certify that by checking the CONFIRM box below and entering my initials below on this release and consent form gives permission to Rose Street Spectrum., the full right to use my child's photograph(s) and/or videotaped image(s) and sound byte(s) in its staff training, educational seminars, and promotional efforts (including brochures and company social networking sites). I willingly agreed to have my child's photograph(s), videotaped image(s), sound byte(s) taken knowing that it could be used in various publications and/or broadcasts in the State of Texas and/or throughout the United States.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

POLICY ON UNATTENDED CHILDREN

Rose Street Spectrum requires that a caregiver over the age of 18 be present at all times while a Tutor or a Consultant is engaged in an in-home or community based session. If for some reason you or another adult caregiver is not available during the session you may submit a formal request asking that you be granted permission to leave your child alone with the Tutor or Consultant during session.

I AGREE FOR ROSE STREET SPECTRUM TO ENGAGE IN COMMUNITY BASED INTERVENTION. By agreeing to this waiver, I do not hold Rose Street Spectrum or its affiliates responsible for any injury, damage of property, or other unforeseen incident that occurs during community based intervention (including the recognition of my limits to confidentiality during such intervention seeing that it is public).

Signature acknowledging this waiver x_____

If you are approved to leave your child alone with the Tutor or the Consultant there must be an adult over the age of 18 present no less **than 5-minutes prior to the end of the session**. Failure to comply with this regulation may result in approval being terminated and reinstating of the requirement that an adult be present at all times.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

COMMUNICATION VIA EMAIL WAIVER

E-mail offers an easy and convenient way for clients and service providers to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember: there are important differences. E-mail is not the same as calling our office; there is no person at the other end of the call – just a computer. You can't tell for certain when your message will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to client care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us using e-mail.

- E-mail is never, ever, appropriate for urgent or emergency problems. Please use the telephone or go to the Emergency Department for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail also include appointment scheduling requests and billing/insurance questions.
- E-mail is not confidential. It is like sending a postcard through the mail. My staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become a part of the medical record when we use it; a copy may be printed and put in your chart.
- E-mail is not a substitute for direct participation in client treatment (i.e. Family Participation Contract). If you think that you might need time to discuss concerns face to face, please call and book an appointment.
- E-mails may be forwarded to my staff for handling, if appropriate.

Finally, either one of us can revoke permission to use the e-mail system at any time.

☐ I DO want to communicate with my Rose Street Spectrum Service Providers electronically. I have read the above information and understand the limitations of security on information transmitted.

3501 Sheppard Access Road
Phone: 940-322-2372 ext. 119
Email: wfspectrum@gmail.com

Client Policy Acknowledgement

Please fill out completely and return to Rose Street Spectrum.

I, _____ and _____ have read, understand and agree to the
(parent/guardian 1) (parent/guardian 2)

policies of Rose Street Spectrum.

Please initial next to each policy you have read and agree to.	**Parent 1's Initials**	**Parent 2's Initials**
Billing Policy and Insurance Submission and Release Authorization		
Payment Policy		
Absence Policy		
Sick Policy		
Medication and Supplement Policy		
Communication Policy		
Open Door Policy		
Late policy		
Required Parent Involvement Policy		
Service Rates		
Waiver and Indemnity Agreement		
Policy on HIPAA		
Policy on Video and Photography Release and Consent Form		
Policy on Unattended Children		
Communication via Email Waiver		