**Initial Assessment Packet**

Intricate Pieces welcomes your family to our services!

We appreciate your time and effort to complete the following document, so that we may proceed with your child’s initial assessment and look forward to meeting you very soon.

|  |  |
| --- | --- |
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Family Demographics

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Social Security Number (child being served): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child have a Diagnosis of Autism?** Yes \_\_ / No \_\_

* Name of medical practitioner who referred child for ABA services (name as it appears on the prescription for services): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Name of medical practitioner who provided diagnosis of Autism:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Please include other diagnoses, if applicable:

**Primary Care Physician**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Contact Information

 **Primary Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Home phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Work phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Preferred method of communication: \_\_\_home /\_\_\_ cell / \_\_\_work /\_\_\_ email

**Secondary Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Home phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Work phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Preferred method of communication: \_\_\_ home / \_\_\_ cell / \_\_\_ work / \_\_\_ email
* Can pick up/drop off child: \_\_\_\_yes / \_\_\_\_no
* Can provide consent for treatment: \_\_\_\_yes / \_\_\_\_no
* Emergency contact: \_\_\_\_yes / \_\_\_\_no

**Other Caregiver** (if applicable) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Home phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Work phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Preferred method of communication: \_\_\_ home / \_\_\_ cell / \_\_\_ work / \_\_\_ email
* Can pick up/drop off child: \_\_\_\_yes / \_\_\_\_no
* Can provide consent for treatment: \_\_\_\_yes / \_\_\_\_no
* Emergency contact: \_\_\_\_yes / \_\_\_\_no

**Other Caregiver** (if applicable) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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* Cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Work phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Preferred method of communication: \_\_\_ home / \_\_\_ cell / \_\_\_ work / \_\_\_ email
* Can pick up/drop off child: \_\_\_\_yes / \_\_\_\_no
* Can provide consent for treatment: \_\_\_\_yes / \_\_\_\_no
* Emergency contact: \_\_\_\_yes / \_\_\_\_no

Insurance Information

* **Primary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Subscriber/member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Policyholder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Secondary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Subscriber/member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Policyholder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Medical History & Current Medications

* Medical Allergies: \_\_ NO \_\_\_ YES
* If yes, please explain
* Food Allergies: \_\_\_ NO \_\_\_ YES
	+ If yes, please explain
* History of Seizure: \_\_\_ NO \_\_\_ YES
	+ If yes, please explain
* Special Diet: \_\_\_ NO \_\_\_ YES
	+ If yes, please explain
* Is there a familial history of mental illness? \_\_\_ NO \_\_\_ YES
	+ If yes, please explain
* Is your child being treated for any chronic medical conditions? \_\_\_ NO \_\_\_ YES
	+ If yes, please explain

Child’s Current Medications:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Dosage | Frequency | Reason |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Developmental History

* Provide a brief description of the child’s pregnancy term, including any complications:
* Describe the child’s developmental history:
* Smiled: N\_\_/Y\_\_ age\_\_\_\_\_\_\_
* Crawled: N\_\_/Y\_\_ age\_\_\_\_\_\_\_
* Walked: N\_\_/Y\_\_ age\_\_\_\_\_\_\_
* Sat up unassisted: N\_\_/Y\_\_ age\_\_\_\_\_\_\_
* Stood: N\_\_/Y\_\_ age\_\_\_\_\_\_\_
* Ran: N\_\_/Y\_\_

age\_\_\_\_\_\_\_

* Said first word: N\_\_/Y\_\_ age\_\_\_\_\_\_\_
* Fed Self: N\_\_/Y\_\_
* age\_\_\_\_\_\_\_
* Potty Trained: N\_\_/Y\_\_ age\_\_\_\_\_\_\_
* Did your child have any significant illnesses during the first 2 years? (i.e.., frequent ear infections, respiratory illnesses, etc.): N\_\_/Y\_\_
	+ If yes, please explain

Therapies:

* Has your child been evaluated by a speech-language pathologist? N\_\_/Y\_\_
	+ If yes, was/is your child treated by a speech-language pathologist? N\_\_/Y\_\_/NA\_\_
* Has your child been evaluated by an occupational therapist? N\_\_/Y\_\_
	+ If yes, was/is your child treated by a physical therapist? N\_\_/Y\_\_/NA\_\_
* Has your child been evaluated by a physical therapist? N\_\_/Y\_\_
	+ If yes, was/is your child treated by a physical therapist? N\_\_/Y\_\_/NA\_\_
	+ Did/Does your child require physical adaptive equipment for mobility? N\_\_/Y\_\_

Behavioral Development

Describe your current behavioral concerns:

* Does your child have tantrums? N/Y
	+ If yes, please describe how these tantrums developed and changed over time:
* Please describe your child’s behavioral challenges and what type of intervention is applied:

|  |  |  |
| --- | --- | --- |
| Date Began (approximate) | Behavior | How behavior is handled: |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Social Development

* Describe current social concerns for your child:
* How does your child interact with same age peers?
* How does your child interact with family members?
* What kinds of play activities does your child enjoy?
* How does your child prefer to spend their time?

Communication History

* What is your child’s primary method of communication?
* How does your child typically communicate his/her wants and needs?
* How does your child communicate regarding toileting needs?
* Other communication concerns:

Family History

* Please list all members of the household, noting if there is more than one residence where the child resides, and their relationship to the child:

Describe any current concerns regarding the child’s home(s) and/or community setting:

* Are there familial traditions/events that are especially important to your child?

If yes, please describe:

* Have there been any significant family changes in your child’s life?

If yes, please describe:

* Does your family have any spiritual, cultural or religious beliefs that influence your child’s development and/or care?

If yes, please describe:

Daycare and/or Educational History

* Is your child currently enrolled in daycare? NO \_\_\_ YES \_\_\_
	+ Approximately how many hours per day, days per week?

Please describe your child’s current daycare setting:

* Did your child attend daycare in the past? N\_\_/Y\_\_

Please describe your child’s prior daycare setting(s):

* Is your child currently enrolled in an educational setting/school? NO\_\_\_ YES \_\_\_
	+ Name of school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Grade Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other applicable care/educational settings your child has participated in:
* What are your child’s academic strengths?
* What are your child’s academic challenges?
* How does your child learn best?
* Please describe your concerns about school, if applicable:
* What is your child’s current Daily Schedule?

Developmental Skills Questionnaire:

Please describe how your child responds to the following:

* Attends to others:
* Listens to peers:
* Initiates interactions with peers:
* Maintains an interaction with peers:
* Attends to / Participates in a group learning environment:
* Organized:
* Able to problem solve:
* Understands feelings of others:
* Adapts to change:
* Affectionate toward others:
* Understands rules and consequences:

Additional Information

* Is there additional information that you feel would be helpful in the treatment of your child?
* Do you have any special requests?
* What else would you like for us to know regarding your child, regarding ABA therapy?
* What goals for your child are most important to you?

**Thank you for taking the time and effort to provide this very important information about your child. We look forward to serving your family.**

The following information and acknowledgements are a considered an agreement between Intricate Pieces, LLC and the family being served. Please read the information carefully and feel free to direct questions/concerns to your Center Administrator and/or Clinical Director (BCBA).

Financial Liability and Consent for Reimbursement:

Intricate Pieces, LLC will verify benefits and pre-authorize services, if necessary, with your insurance company. A quote of benefits is not a guarantee of payment from your insurance company. It is the primary insurance policy holder’s responsibility to notify Intricate Pieces of any changes to the policy/benefits that may impact billing and/or treatment. Please verify coverage benefits with the insurance company if you have questions or concerns.

Intricate Pieces, LLC is committed to serving your family in a professional and fiscally responsible manner however, situations may arise in which payment is denied for services. If such circumstances arise, the guardian is liable for charges incurred.

* If we are unable to courtesy bill your insurance company, you personally may be able to submit receipts directly to your insurance company for services rendered to obtain reimbursement. We will gladly provide you with receipts and supporting documentation for your insurance provider after services are paid and delivered. Since dates of service are required for reimbursement, services need to be delivered when submitting to payor.

I have read and understand the above statements. I acknowledge that I have been informed that my insurance carrier may deny or discontinue services for a variety of reasons, outside the control of Intricate Pieces.

* I understand that I am financially responsible to the provider for all charges not covered or not paid by my insurance plan within thirty (30) days after billing. I also understand that the insurance company may require payment for the estimated noncovered charges before the completion of an insurance bill or claim. The
* Assignment of Benefits provided is valid until the primary policy holder cancels it in writing.

I hereby authorize release of medical information to the provided insurance carrier for payment of benefits, otherwise payable to me, for services rendered by Intricate Pieces, LLC and/or as indicated on the enclosed bill or claim.

* **Policy Holder Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Policy Holder’s Relationship to child served:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assignment of Benefits:

By signing below for the assignment of benefits, I hereby authorize payment of benefits, otherwise payable to me, for services rendered by the provider, Intricate Pieces, LLC and/or as indicated on the enclosed bill or claim. I understand that I am financially responsible to the provider for all charges not covered or not paid by my health care benefit plan within thirty (30) days after billing. I also understand that the provider

may require that I pay the estimated non-covered charges before the completion of an insurance bill or claim. This Assignment of Benefits is valid and in force until I cancel it in writing.

* **Policy Holder Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Policy Holder’s Relationship to child served:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIPAA Visiting Observer Privacy Agreement:

The **Privacy Rules** issued under the **Health Insurance Portability and Accountability Act** **(HIPAA)** protect the confidentiality of medical, educational, and personal information of everyone receiving healthcare related services. HIPAA prescribes standards for the privacy and security of client medical information to ensure confidentiality.

HIPAA pertains to any information, in any form, including electronic, written, verbal and other media. When a “*Visiting Observer”* attends an Intricate Pieces center, you are required to follow HIPAA guidelines to protect the confidentiality of our clients’ information. During your

 visits, downloading client information into any device, photographing clients or other visitors, or use or disclosure of any client information, is prohibited.

**Protected Health Information (PHI)** consists of individually identifiable health information that is created or received by Intricate Pieces, LLC and related to the past, present, or future physical or mental health or condition of an individual.; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual.

Such information may not be disclosed except as authorized by the law or as authorized by a client’s parent/legal guardian. These privacy laws and regulations apply to all persons, including all persons conducting observations in clinical settings. All observers are required to agree to and sign this confidentiality statement. I understand that, as an observer/bystander, I may see, hear, or be exposed to confidential information about clients, such as medical information, information regarding a client’s disability, treatment progress, and services received, or other treatment related information about a client. I acknowledge that it is my responsibility to respect the privacy and confidentiality of this information.

I will not access, use, or disclose any confidential information outside of my observation of the client listed below. I understand that if I breach any provision of this Agreement, I may be subject to civil or criminal liability.

* **Client Name (Print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Parent Name (Print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to Treat:

An initial assessment consists of a historical file review, skills-based assessments, and standardized assessments. Throughout the assessment process, you have the right to inquire about the nature or purpose of all tests and procedures. You also have a right to know the test results, interpretation of results and of recommendations provided by the clinician.

Intricate Pieces conducts assessment protocols associated with autism spectrum disorder, and associated functioning. So that the clinician may obtain relevant information to your child’s assessment and future treatment, should they be enrolled, a historical file review will be conducted including medical records, school records and any relevant medical testing provided by other healthcare providers. Additionally, the clinician will administer a combination of standardized and skills assessments, including but not limited to the following: VB-MAPP; ABLLS-R; Vineland-III, SRS-2 and PDDBI.

Feedback provided may include a comprehensive written summary consisting of an overview of findings and recommendations, in person or via telephone, in a parent summary meeting. If you proceed with treatment following the initial assessment, a Treatment Plan will also be discussed. Parent/Caregiver collaboration is essential to the success of ongoing treatment therefore, it is the goal of Intricate Pieces to consult and collaborate with you, to design a comprehensive and individualized treatment plan.

Informed Consent:

By signing below, I acknowledge that I am consenting to treatment provided by Intricate Pieces. I understand that I have the right to discontinue the evaluation at any time. I fully understand my rights and responsibilities and freely agree to this evaluation.

* **Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Parent/Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Photograph and Videotaping Consent

Please read and attest to the Photography and videotaping consent. Identifiable photos and videos, even without any other identifying information, are considered Protected Health Information (PHI) and are protected under HIPAA. You have the right to choose how Intricate Pieces handles your child’s identifiable photos and videos.

**Photography & Video Consent for Assessment, Treatment and Training Purposes:**

* **I DO** give permission to Intricate Pieces, LLC to take photographs and/or video of my child. I understand that the photographs and/or video of my child may be included for purposes of assessment and/or professional training purposes.
	+ **Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ **Parent/Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

* **I DO NOT** give permission to Intricate Pieces, LLC to take photographs and/or video of my child. I understand that the photographs and/or video of my child may be included for purposes of assessment and/or professional training purposes.

Photography & Video Consent for Marketing Purposes:

* **I DO** give permission to Intricate Pieces, LLC to take photographs and/or video of my child for purposes of marketing materials, with or without other children included, to be shared through various marketing channels. I understand that this a voluntary agreement and will not affect my child’s therapy program and can be revoked at any time.
	+ **Child’s name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ **Parent/Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

* **I DO NOT** give permission to Intricate Pieces, LLC to take photographs of my child for purposes of marketing materials, with or without other children included, to be shared through various marketing channels. I understand that this a voluntary agreement and will not affect my child’s therapy program and can be revoked at any time.

Non-Discrimination Notice

**Discrimination Is Against the Law:**

Intricate Pieces, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Intricate Pieces does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Intricate Pieces provides free reasonable access and services to people with disabilities and to people whose primary language is not English to communicate effectively with us, including:

 Qualified interpreters

* + - Information written in other languages

**If you need these services, contact your child’s care team at your Center.**

If you believe that Intricate Pieces, LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance in writing with your child’s care team, or with:

 Rick Johnson

Chief Clinical and Compliance Officer

Intricate Pieces, LLC

16635 Spring Cypress Rd, Unit 1807

Cypress, TX 77429

You may file a grievance by mail, or email.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

HHS complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Patient Bill of Rights and Responsibilities

Intricate Pieces, LLC is dedicated to helping children with developmental disabilities achieve their potential in family, community, and school life. We care about the dignity and welfare of all who receive services from us.

Although these rights are written for the patient, in most cases they also apply to the patient's parents or legal guardians. We expect staff, patients, families, and visitors to act in a reasonable and responsible way always.

If you have a concern about any of these rights or responsibilities, you may discuss it with the staff involved, their supervisor or our Clinical Director. If you are still concerned, you may also speak with the Chief Clinical and Compliance Officer's office by coordinating with the Clinical Director.

Your Rights

* You have the right to considerate, respectful care always and under all circumstances, with recognition of personal dignity.
* You have the right, within the law, to personal and informational privacy.
* You have the right to expect reasonable safety insofar as the center’s practices and environment are concerned.
* You have the right to verbal and written communications.
* You have the right to refuse treatment to the extent permitted by law. When the refusal of treatment by a client, or their legally authorized representative, prevents the

provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice.

* You have the right to expect that Intricate Pieces staff is competent to obtain and interpret information in terms of your needs and to understand the range of treatment needed.
* The family and/or guardian of the client have the right to be involved in the patient’s continuing care.
* You have the right to assistance for conflicts regarding services rendered. If applicable, the assigned Intricate Pieces provider should always be made aware of any conflict.
* If resolutions of conflict cannot be achieved with the patient/family through the professionals involved, the patient/family has the right to request a meeting with the Clinical Director who has the ultimate authority in resolving conflicts.

Your Responsibilities:

* Provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your child’s health.
* Follow treatment plans recommended by the Intricate Pieces practitioners.
* Be responsible for your actions if you refuse treatment or do not follow the practitioner’s instructions.
* Assure that the financial obligations of your child’s health care/service are fulfilled as promptly as possible.
* Be responsible for keeping your insurance information/coverage/policy numbers up to date with Intricate Pieces.
* Be considerate of the rights of other patients and the Intricate Pieces staff for assisting in the control of noise and number of visitors.
* Be respectful of the property of the other persons and the Intricate Pieces treatment facility.
	+ **Child’s name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ **Parent/Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for taking the time and effort to read and acknowledge the information in this Initial Assessment Packet.

We look forward to seeing you and your child at your upcoming appointment.