Dear new family,

We are excited to share more about our services. As we begin, the initial steps include the completion of the following intake packet and the submission of necessary documents. As we get closer to starting services, we will schedule an initial consultation with a board certified behavior analyst.

Required to begin ABA services:

1. Provide insurance information including a photocopy of your insurance card 2. Complete intake packet and return to MethodWorks via mail, fax, or in-person:

MethodWorks
PO Box 241224
Anchorage, AK 99524

Email: intake@methodworks-ak.com
Fax: (907)677-7017

Each child's treatment plan is unique to them and is based on observations, interviews with key family members/caregivers, and the completion of formal assessments. During the initial assessment process, the BCBA and family determine specific treatment goals. Once treatment goals are developed, the BCBA will craft a treatment plan.

The amount of therapy time needed varies from child to child and tends to range from 12 hours a week to 35 hours a week. Parents and other family members play a key role in the success of their child's therapy and part of your child's treatment plan will include training for you and other key caregivers.

We look forward to getting to know you and your child better.

Sincerely,

Phil Tafs
CEO
MethodWorks

MethodWorks
BEHAVIORAL STRATEGIES (Formerly PCR Alaska)

INTAKE PACKET CHECKLIST

Please fax or mail a copy of the following to 209-759-2653 or ABA Program Intake, MethodWorks, PO Box 241224, Anchorage, AK 99524.

Please provide copies of:

__ Prescription for ABA intervention from a qualified medical provider (required)
__ Copy of neuropsychological evaluation
__ Copy of IEP (if applicable)
__ Photo of insurance card (front and back)

Please complete the following intake forms:

__ Signed parent contract
__ Completed schedule availability sheet
__ Completed release of information for teacher, pediatrician and other providers
__ Signed confidentiality agreement
__ Signed video and photo release
__ Signed permission slip for field trips and transportation
__ Completed medical information sheet
__ Completed reinforcer questionnaire
__ Completed insurance information and authorization form
__ Signed financial responsibilities form

Contract for Services

Child's Name ___________________________ Child's Address:___________________________
DOB ___________________________________ City:_____________ State:_____ Zip:________
Mother _________________________________ Phone: __________________________________
Father _________________________________ Phone:___________________________________
Other Guardian __________________________ Phone:___________________________________

Service Overview

Hours of Operation for Services

By appointment/as agreed upon by team.

Services

Assessments for strengths, skill deficits and intervention goals
Function-based assessment of problem behaviors and recommendations
Intervention services
Paraprofessional and parent instruction/education

Other Information

Program information

This type of intervention is systematic and precise

Team members may include:

home - parents, line therapists, respite care providers, and consultant
extended - speech/language pathologists, occupation and/or physical therapists, pediatrician, school team, and/or other professionals involved with the child.
- requires all team members to consistently implement all prescribed programs
- the focus is on ***increasing*** adaptive, communicative, daily living skills, and functionally equivalent behaviors for problematic behaviors – we do not endorse physical punishment and request that the parents refrain from using corporal punishment, relying instead on the procedures outlined by the consultant.
- is based on what is best for the child and is compatible with family needs

<u>Structure</u>

Autism Services

- typically requires initial team meetings once a week until the program is fully implemented. All team members are required to attend and participate in all team meetings. Because programs change, some programs are implemented at team meetings. If for some reason a member misses a team meeting, it is his/her responsibility to read the team meeting notes to identify

program changes, modifications, or additions and communicate with the team lead or consultant to clarify any questions.

-as the child progresses, team meetings can be reduced to 2x/month (depends on individual child needs)

-requires a designated RBT. This individual should be familiar with programs, data collection, and behavior intervention techniques. This individual is responsible for ensuring that the data is graphed and the binder is ready for team meetings.

-it is necessary to ensure 15 minutes at the beginning of the session to read notes from previous therapists and 15 minutes at the end of the session.

Outline of Procedures

-Some of the procedures will require physical prompting.

-All MethodWorks staff are properly trained

-If you have your own, untrained staff, MethodWorks is not and will not be held liable for any procedures or actions that might take place.

Parent Training

- typically involves meeting with a provider weekly, but may be more or less frequent depending on individual needs
- will involve work both in and out of session
  - persons participating in therapy may be asked to check-in with the provider between sessions to help ensure treatment progress, prevent regression, and identify potential issues

Cost/Payment Information

Behavior Analytic Services & Parent Training

Please contact the office to inquire as to whether we work with your insurance carrier.

- private pay
- private insurance (when applicable)
- Medicaid (when applicable)
- Combination of the above methods

CONDITIONS

Consultation Team

We, as the behavioral consultant team, will complete any assessments necessary for the treatment recommendations for the client.

Consultant

I, as the consultant, will make every reasonable effort to provide high quality and effective behavioral programming, including observations, progress review and program assessment to ensure successful interventions.

MethodWorks does not offer on-call coverage for ABA services on a 24-hour basis. Clients may contact the MethodWorks BCBA and/or program manager with questions or comments via telephone or email in between team meetings. Every effort will be made to return contact within one business day. MethodWorks will make every reasonable effort to be available for problem solving, programming changes, parent training, and questions.

During times of extended absences (e.g. vacation and/or leave), appropriate contact information will be made available to clients.

Parents

Program Responsibilities

I/we the parents of this child will make every reasonable effort to follow the recommendations of the BCBA and MethodWorks staff with regard to programming/instructional recommendations for my/our child. This includes procedures designed to reduce problematic behaviors.

I/we, the parents of this child, understand that each child is unique, that my child's program is tailored for his/her unique needs, and that as the function of the behavior changes, so does the intervention technique.

I/we, the parents of this child understand that to ensure the success of the program, which is my/our responsibility to:

1. Ensure that reinforcers are freely available to all therapists for use during instruction time.
2. Ensure that reinforcers are restricted for use ONLY during therapy time or parent programming.
3. Bring up any casual concerns (e.g., absent child) should be discussed with the consultant.
4. Refrain from bringing up topics such as the other children, parents, or the personal lives of anyone involved with MethodWorks.
5. Attend the scheduled progress meetings and parent training.
6. Provide an emergency number where you can always be reached during therapy sessions.
7. Ensure the child is ready for his/her session at the beginning of the scheduled session.
8. Carry out agreed upon teaching and behavior reduction procedures developed in the progress meetings and consult with a consultant if you would like to make changes. You must complete daily home assignments and maintain required data on assigned topics.
9. Follow through in a timely fashion on MethodWorks requests for therapy items.
10. Commit to an evidence-based approach (intensive, consistent intervention) including being available for the minimum number of hours of intervention recommended by the consultant.
11. Refrain from implementing other treatments/therapies that might interfere with the success of the program, if you have other ideas or input from other specialists the consultant will be made aware of the request..
12. Relay all treatment team concerns ONLY to the consultant and/or team lead and discourage staff from talking about personal concerns with you.
13. Participate in regularly scheduled re-evaluations as necessary to assess treatment progress and need for updated programing.
14. Pay any necessary fees for service in a timely manner in accordance with MethodWorks' billing policy.

I/we, the parents of this child also understand that if a child is available for less than 80% of his recommended treatment time, or if two (2) consecutive parent meetings are canceled or if three (3) parent meetings are missed within a four (4) month period, then the contract and services offered will have to be reviewed before services can continue.

I/we, the parents of this child understand that if the child is sent home from school due to illness, or has had an extreme runny nose, fever, or severe cough; then services for that day are canceled. It is up to me/us, the parents of this child, to contact any and all providers scheduled for the day that the child is sick and services are canceled.

Appointment Information

I/we the parents of this child will make every reasonable effort to keep all appointments. I/we understand that if cancellations cannot be made 24 hours prior to the appointment time rescheduling of appointments will occur on a first come, first serve basis.

****This contract is renewable on an annual basis. Updates and changes are made from year to year and 4 a new signed contract is required for services to continue.

Your signature below indicates that you have received and read the information in this document. Consent by all parents/legal guardians is required prior to the assessment for and implementation of ABA services.

These policies have been fully explained to me and I fully and freely give my consent for services to be implemented as proposed.

Name Relationship to Child Date

Name Relationship to Child Date

Name BCBA Date

Help us get to know your child…

Think about what your child might do if they had half an hour to do whatever they wanted. What types of things would they do, what foods would they eat, what would they talk about, and what games would they play?

Individual activities

____
____
____
____
____
____
____

Interests/Conversation Topics

____
____
____
____
____
____
____

Activities with someone else

____
____
____
____
____
____
____

Games

____
____
____
____
____
____
____

Toys

____
____
____
____
____
____
____

Foods

____
____
____
____
____
____
____

1. Are there any particular activities or types of interactions your child dislikes?

2. What advice can you offer to a staff member working to build rapport with your child?

Family Information and Emergency Contacts

Caregiver's Name: ________________ Relationship to child: __________________________
Address: __________________________________ Email: ___________________________
____ Cell number: ____________________
____ Work number: ____________________

Caregiver's Name: ________________ Relationship to child: __________________________
Address: __________________________________ Email: ___________________________
____ Cell number: ____________________
____ Work number: ____________________

A trusted adult outside the home
Caregiver's Name: ________________ Relationship to child: __________________________
Address: __________________________________ Email: ___________________________
____ Cell number: ____________________
____ Work number: ____________________

Caregiver's Name: ________________ Relationship to child: __________________________
Address: __________________________________ Email: ___________________________
____ Cell number: ____________________
____ Work number: ____________________

Does the child have siblings?

Name: _____________________ Age: _________
Name: _____________________ Age: _________
Name: _____________________ Age: _________
Name: _____________________ Age: _________
Name: _____________________ Age: _________
Name: _____________________ Age: _________
Name: _____________________ Age: _________

Scheduling Therapy Blocks

Child availability

Recommended treatment hours usually range between 12 hours and 30 hours a week, depending on the age and needs of the child. The BCBA will make recommendations regarding the amount of treatment time needed based on parent interviews, observations, assessments, and identified treatment targets. Please let us know yours and your child's typical availability for services by adding a checkmark, N or – in the boxes below.

✔ = available and preferred N = can be available if needed - = not available

			Monday	Tuesday	Wednesday	Thursday	Friday
7:00	8:00	am					
8:00	9:00	am					
9:00	10:00	am					
10:00	11:00	am					
11:00	12:00	pm					
12:00	1:00	pm					
1:00	2:00	pm					
2:00	3:00	pm					
3:00	4:00	pm					
4:00	5:00	pm					
5:00	6:00	pm					

Parent availability (for intervention training and meetings with clinical team)

			Monday	Tuesday	Wednesday	Thursday	Friday
7:00	8:00	am					
8:00	9:00	am					
9:00	10:00	am					
10:00	11:00	am					
11:00	12:00	pm					
12:00	1:00	pm					
1:00	2:00	pm					
2:00	3:00	pm					
3:00	4:00	pm					
4:00	5:00	pm					
5:00	6:00	pm					

Does your child have any appointments or other upcoming schedule commitments?

Are there any upcoming travel dates or dates the family will be unavailable for therapy or meetings?

Medical Information

Child Name: ________________________________ Date of Birth: ______________

Does your child have any medical conditions that our staff should be aware of? Yes or No
If yes, please describe:

Please list the medication your child current takes:

medication dosage

1.
2.
3.
4.
5.
6.

Does your child have any allergies that our staff should be aware of? Yes or No
If yes, please describe:

Allergen	Symptoms/Reactions	Is it an emergency situation? Y or N	If so, please describe the emergency protocol – please attach a written form if more space is needed

I will update MethodWorks when medication changes or if a new medical condition develops.

Initials: ____

In an emergency, I give permission for my child to receive medical treatment.

Initials: ____

_________________________________ __________
Parent Signature Date

MethodWorks
BEHAVIORAL STRATEGIES (Formerly PCR Alaska)

Release Form for Use of Photos and Video Recording Images

I hereby give my permission for MethodWorks to use photos and video recording for observations, analysis and staff support.

I understand that I may withdraw permission for use of photos and video footage at any time by submitting my request in writing to the supervising BCBA or the clinical director.

Printed Name (or name of individual): ____

Relationship to individual: ____

Individual/Guardian Signature: ____

Date: ____

Confidentiality Agreement

I. **Purpose.** The purpose of this Confidentiality Agreement is to protect the identity and privacy of our clients. Visitors and volunteers at MethodWorks may encounter personal and sensitive information about our clients. Therefore, it is important to refrain from disclosing any information to third parties about our clients, in order to avoid causing them harm.

II. **Confidential Information.** Confidential client information should never be discussed in the presence of third parties, except under the Terms outlined below. Visitors or volunteers at MethodWorks should never have access to files and/or documents containing confidential information. However, in any case, such information should never be shared or released to third parties, except under the Terms outlined below. Confidential Information includes, but is not limited to, the following:

1. Identifying information about the client, including name, address or phone number;
2. Information relating to the client's family;
3. Information regarding the client's medical status or diagnosis;
4. Information about the assessment, treatment, and/or interventions received by the client; or 5. Any other information that would identify the client, or potentially place the client and/or family members at risk.

III. **Terms.** By signing this Confidentiality Agreement, you agree to the highest ethical standards and to abide by the following provisions:

1. All communications between MethodWorks staff, visitors, volunteers, and clients are confidential;
2. Visitors and volunteers shall not disclose confidential information to a third party without the parent/guardian's express consent to release such information;
3. Visitors and volunteers shall not disclose confidential information to a third party without MethodWorks knowledge and consent;
4. I understand that as a visitor or volunteer, I have a duty to keep client information confidential throughout and after my relationship with MethodWorks ends;
5. I understand that my failure to abide by the terms of this Confidentiality Agreement may result in the termination of my participation as a visitor or volunteer at MethodWorks, or restrict opportunities for future access to MethodWorks.

I, ____ (print name), have read MethodWorks' Confidentiality Agreement, and understand its terms and my responsibilities.

____ ________________________

Signature of Visitor of Volunteer Date

Pediatrician

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Name:____ SS #:_____________________________

Date of Birth: _____/_____/______ Telephone #: ________________ Wk#: ____________________

Street Address: _________________________ City: __________________ State: _____ Zip:________

I hereby authorized the two agencies and/or persons listed below to exchange information regarding my case. This information shall be used for the benefit and mutual planning of care services.

Agency &/or Person: **MethodWorks**

Street Address: **3105 Lakeshore Dr.** City: **Anchorage** State: **AK** Zip: **99517**

Phone: **907-302-9164** Fax: **N/A**

Agency &/or Person: ____

Street Address: ___________________________________ City: _____________ State: ____ Zip: ______

Phone: ______________________________ Fax: ____________

The type and amount of information to be used or released is checked below:

__X__ All Records/Information

_____ Dental

__X__ Medical Records, including diagnosis

__X__ Program plans, Evaluations, & Assessments

__X__ Psychological Evaluation, IQ score & Tests

__X__ School Records

__X__ Social History

__X__ Other:

This information may be released in the following format(s):

__X__ Audio/Visual __X__ Electronic __X__ Verbal __X__ Written __X__ Other

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency Syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

I understand that this authorization may be revoked by the person served and/or their guardian at any time except to the extent that action has already taken place. I understand that if I revoke this authorization I must do it in writing and present my written revocation to the information management department. Unless otherwise revoked, this authorization will expire on ______/_______/______

(Not to exceed one year from the date of signature)

I have read the above Authorization for Release of Information/Permission to Obtain and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this release.

Date:____/____/______ Signature of Person Served:____

Date:____/____/______ Signature of Authorized Representative:________________________________

Representative:____

(**Please complete the following section if signed by a Parent, Guardian, or Authorized Representative)

Printed Name of Parent/Guardian of Authorized Representative:__________________________________

Street Address:______________________________ City:_____________________ State:___ Zip:_____

Phone:__________________________ Relationship to the Person: ______________________________

Speech/OT/Other Provider

MethodWorks
BEHAVIORAL STRATEGIES (Formerly PCR Alaska)

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Name:____ SS #:______________________________
Date of Birth: _____/_____/______ Telephone #: ________________ Wk#: ____________________
Street Address: __________________________ City: ___________________ State: _____ Zip:________

I hereby authorized the two agencies and/or persons listed below to exchange information regarding my case. This information shall be used for the benefit and mutual planning of care services.

Agency &/or Person: **MethodWorks**____
Street Address: **3105 Lakeshore Dr.**____________________City: **Anchorage**____ State: **AK** Zip: **99517**_
Phone: **907-302-9164**________________ Fax: **N/A**__________

Agency &/or Person: ____
Street Address: ____________________________________ City: _____________ State: ____ Zip: ______
Phone: ______________________________ Fax: ____________

The type and amount of information to be used or released is checked below:

__X__ All Records/Information
_____ Dental
__X__ Medical Records, including diagnosis
__X__ Program plans, Evaluations, & Assessments
__X__ Psychological Evaluation, IQ score & Tests
__X__ School Records
__X__ Social History
__X__ Other:

This information may be released in the following format(s):
__X__ Audio/Visual __X__ Electronic __X__ Verbal __X__ Written __X__ Other

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(Not to exceed one year from the date of signature)

I have read the above Authorization for Release of Information/Permission to Obtain and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this release.

Date:____/____/______ Signature of Person Served:____

Date:____/____/______ Signature of Authorized Representative:_______________________________
Representative:____
(**Please complete the following section if signed by a Parent, Guardian, or Authorized Representative)

Printed Name of Parent/Guardian of Authorized Representative:__________________________________
Street Address:________________________________ City:______________________ State:___ Zip:_____
Phone:___________________________ Relationship to the Person: ________________________________

Speech/OT/Other Provider

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Name:____ SS #:______________________________
Date of Birth: _____/_____/______ Telephone #: ________________ Wk#: ____________________
Street Address: __________________________ City: ___________________ State: _____ Zip:_________

I hereby authorized the two agencies and/or persons listed below to exchange information regarding my case. This information shall be used for the benefit and mutual planning of care services.

Agency &/or Person: **MethodWorks**____
Street Address: **3105 Lakeshore Dr.**____________________City: **Anchorage**____ State: **AK** Zip: **99517**_
Phone: **907-302-9164**_______________ Fax: **N/A**__________

Agency &/or Person: ____
Street Address: ____________________________________ City: _____________ State: ____ Zip: ______
Phone: ______________________________ Fax: ____________

The type and amount of information to be used or released is checked below:

__X__ All Records/Information
_____ Dental
__X__ Medical Records, including diagnosis
__X__ Program plans, Evaluations, & Assessments
__X__ Psychological Evaluation, IQ score & Tests
__X__ School Records
__X__ Social History
__X__ Other:

This information may be released in the following format(s):
__X__ Audio/Visual __X__ Electronic __X__ Verbal __X__ Written __X__ Other

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency Syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

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(Not to exceed one year from the date of signature)

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Date:____/____/______ Signature of Person Served:____

Date:____/____/______ Signature of Authorized Representative:__________________________________
Representative:____
(**Please complete the following section if signed by a Parent, Guardian, or Authorized Representative)

Printed Name of Parent/Guardian of Authorized Representative:____________________________________
Street Address:________________________________ City:______________________ State:___ Zip:_____
Phone:___________________________ Relationship to the Person: ________________________________

Speech/OT/Other Provider

MethodWorks
BEHAVIORAL STRATEGIES (Formerly PCR Alaska)

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Name:____ SS #:_____________________________
Date of Birth: _____/_____/______ Telephone #: ________________ Wk#: ___________________
Street Address: _________________________ City: __________________ State: _____ Zip:________

I hereby authorized the two agencies and/or persons listed below to exchange information regarding my case. This information shall be used for the benefit and mutual planning of care services.

Agency &/or Person: **MethodWorks**____
Street Address: **3105 Lakeshore Dr.**____________________City: **Anchorage**____ State: **AK** Zip: **99517**_
Phone: **907-302-9164**_______________ Fax: **N/A**__________

Agency &/or Person: ____
Street Address: ___________________________________ City: _____________ State: ____ Zip: ______
Phone: ______________________________ Fax: ____________

The type and amount of information to be used or released is checked below:

__X__ All Records/Information
_____ Dental
__X__ Medical Records, including diagnosis
__X__ Program plans, Evaluations, & Assessments
__X__ Psychological Evaluation, IQ score & Tests
__X__ School Records
__X__ Social History
__X__ Other:

This information may be released in the following format(s):
__X__ Audio/Visual __X__ Electronic __X__ Verbal __X__ Written __X__ Other

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency Syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

I understand that this authorization may be revoked by the person served and/or their guardian at any time except to the extent that action has already taken place. I understand that if I revoke this authorization I must do it in writing and present my written revocation to the information management department. Unless otherwise revoked, this authorization will expire on ______/_______/______
(Not to exceed one year from the date of signature)

I have read the above Authorization for Release of Information/Permission to Obtain and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this release.

Date:____/____/______ Signature of Person Served:_______________________________________

Date:____/____/______ Signature of Authorized Representative:_____________________________
Representative:____
(**Please complete the following section if signed by a Parent, Guardian, or Authorized Representative)

Printed Name of Parent/Guardian of Authorized Representative:____________________________
Street Address:______________________________ City:_____________________ State:___ Zip:_____
Phone:__________________________ Relationship to the Person: ______________________________

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Name:____ SS #:____________________________
Date of Birth: _____/_____/______ Telephone H#: ________________ Wk#: ___________________
Street Address: _________________________ City: __________________ State: _____ Zip:________

I hereby authorized the two agencies and/or persons listed below to exchange information regarding my case. This information shall be used for the benefit and mutual planning of care services.

Agency &/or Person: **MethodWorks**____
Street Address: **3105 Lakeshore Dr.**___________________City: **Anchorage**____ State: **AK** Zip: **99517**_
Phone: **907-302-9164**_______________ Fax: **N/A**__________

Agency &/or Person: ____
Street Address: ___________________________________ City: _____________ State: ____ Zip: ______
Phone: _____________________________ Fax: ____________

The type and amount of information to be used or released is checked below:

__X__ All Records/Information
_____ Dental
__X__ Medical Records, including diagnosis
__X__ Program plans, Evaluations, & Assessments
__X__ Psychological Evaluation, IQ score & Tests
__X__ School Records
__X__ Social History
__X__ Other:

This information may be released in the following format(s):
__X__ Audio/Visual __X__ Electronic __X__ Verbal __X__ Written __X__ Other

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency Syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

I understand that this authorization may be revoked by the person served and/or their guardian at any time except to the extent that action has already taken place. I understand that if I revoke this authorization I must do it in writing and present my written revocation to the information management department. Unless otherwise revoked, this authorization will expire on ______/_______/______
(Not to exceed one year from the date of signature)

I have read the above Authorization for Release of Information/Permission to Obtain and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this release.

Date:____/____/______ Signature of Person Served:____

Date:____/____/______ Signature of Authorized Representative:_______________________________
Representative:_______________________________________
(**Please complete the following section if signed by a Parent, Guardian, or Authorized Representative)

Printed Name of Parent/Guardian of Authorized Representative:_______________________________
Street Address:______________________________ City:_____________________ State:___ Zip:_____
Phone:__________________________ Relationship to the Person: ______________________________

Waiver of Liability Form

Attachment to MOA Between
Anchorage School District (ASD)
and

_____MethodWorks (Previously PCR Alaska)_____(Service Provider)

My signature below indicates I am in agreement with the treatment plan for _______________ ____________which includes a staff member from the above listed service provider being assigned to be present in the school and provide services as outlined in the Memorandum of Agreement to assist this child in the classroom and/or other designated school environment. I understand that this staff member is employed by the Service Provider and not by the Anchorage School District (ASD). ASD is not responsible for any actions taken by the Service Provider or by the staff member(s) assigned to my child.

I release the Anchorage School District from any liability and agree not to sue ASD on account of, or in relation to, any claims or damages that arise from or are connected to any services or actions by the Service Provider and/or its staff assigned to my child. This release includes, but is not limited to, injuries based on death, bodily injury, disability, or property damage, I understand that in releasing ASD, I am also releasing all ASD employees, agents, and School Board.

By signing below, I acknowledge that I have read and understand the Waiver of Liability and that I am freely and voluntarily waiving claims as set forth above.

____
Print Name (Parent or legal guardian)

_____________________________________ ___________________
Signature Date

- *Copies of this completed form will be maintained at:*
    - *ASD – in specific school where the child is receiving services*
    - *Service Provider/Company providing services*

ANCHORAGE SCHOOL DISTRICT
CONSENT FOR RELEASE OF EDUCATION RECORDS

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF EDUCATION RECORDS

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records created or maintained by a school that receives federal funds. Completion of this document authorizes the disclosure and use of education records as described below. Completion also authorizes you to discuss this information with representatives of the organization named below entitled to receive said information.

STUDENT INFORMATION:

Student Name: ______________________________ Date of Birth: ____________________

Social Security Number: __________________________ Grade: ______________________

School: ____

Parent/Legal Guardian Name: ____

Relationship to Student: ____

USE AND DISCLOSURE INFORMATION:

I, the undersigned, do hereby authorize ____________________ (*name of agency or educational institution maintaining records*)

to disclose and deliver the complete education records maintained under the above student's name including but not limited to the following:

* Grades and transcripts
* School health records
* Psychological & Educational testing
* Special education records
* Verbal Information
* Discipline

***Please list any records you do not wish to be disclosed*: ______________________________

The education records described above shall be delivered to:

Name: ________________________ Organization: MethodWorks____________________

Address: 3105 Lakeshore Drive____

City/State/Zip Code: Anchorage, AK 99517______________ Telephone Number: 907-302-9164________

PURPOSE:

This information is to be disclosed and used for the purpose of:

__ Special Education Evaluation & Planning
__ Provision of Special Education Services
__ § 504 Evaluation & Planning
__ Information for School Nursing
__ Other ____ (*please provide explanation*).

AUTHORIZATION FOR REDISCLOSURE:

Under federal law, the requestor (School District) may not redisclose the information identified above to any other party without your prior consent. If you wish to authorize the School District to redisclose the information identified above please mark the box below:

__ I authorize the School District to redisclose the education information described above and I understand that if the information is disclosed it may not be protected by federal privileges, privacy laws or regulations.

APPROVAL:

My authorization for the use, disclosure and/or redisclosure of the information identified above is voluntary. I understand that the information to be disclosed or redisclosed may include individually identifiable health information. I understand that, upon my request, I am entitled to a signed copy of this authorization form and the records to be disclosed. Unless sooner terminated in writing, this release shall remain effective for **1 year** from the date signed below. A copy of this release shall be as sufficient to authorize release of information identified above as the original signed by me.

______________________________ Date: ____________________

Signature of Student's Parent or
Student's Legal Guardian

Relationship: ______________

MethodWorks
BEHAVIORAL STRATEGIES (Formerly PCR Alaska)

FINANCIAL POLICY STATEMENT

Thank you for choosing MethodWorks as your ABA Therapy Provider. We will strive to provide the best possible care for you and your family. As a part of these efforts, we want to establish and communicate our financial policy to our families and we want you to feel confident that you completely understand MethodWorks' Financial Payment Policy. The following information outlines your financial responsibilities related to payment for our professional services.

1. Insurance: We accept many health plans that include an ABA Therapy benefit. We have contracts with several insurance companies and government agencies including Medicaid. MethodWorks will submit claims for any services rendered to a patient who is a member of one of these plans and will work diligently to get your claims paid. It is the patient's responsibility to provide all necessary information prior to the start of treatment.

2. Secondary Insurance: If you have a secondary insurance plan we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is the patient's responsibility to comply with these requests in order to prevent faulty billing, unpaid claims, and/or unnecessary denials of claims.

3. Verification of Benefits: As a courtesy to our patients, MethodWorks will verify your benefits and eligibility with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claims will process according to your plan, if your claims processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. Be sure to check with your insurance company's member benefits department about services and providers before the start of treatment.

4. Insurance pre-authorization of ABA services: MethodWorks will submit pre authorization requests per insurance carrier guidelines, when applicable. Services will not be delivered or may be put on hold until pre-authorization is obtained from your insurance company. Once obtained, pre-authorization is not a guarantee of payment.

5. Payments: Insurance is a contract between the patient and their insurance company. Although the insurance companies frequently pay claims for the services we provide, the patient is ultimately responsible for payment in full. Payment is expected at the time of invoice. Invoices are mailed to you via the US Mail each month. At this time, we can only accept payments made via check or money order. Invoices will include any unmet deductible, coinsurance, co-payment amount, or non-covered charges from your insurance company. Payment is accepted at the time of the invoice unless you have set up a written payment plan with our CEO, Phil Tafs.

6. Delayed Payments: MethodWorks will bill you directly, if your insurance company does not pay MethodWorks.

Your signature below indicates that you have received and read the information in this document.

Printed Name ___________________________ Signature _____________________________

Relationship to Child _____________________ Date ____________

MethodWorks
BEHAVIORAL STRATEGIES (Formerly PCR Alaska)

INSURANCE BILLING INFORMATION AND AUTHORIZATION

___ I am a private pay client/patient and acknowledge it is my personal responsibility to pay for services.

___ I authorize my insurance provider(s) listed below to make payments directly to MethodWorks for services rendered. I understand that MethodWorks bills insurance as a courtesy and that I am ultimately responsible for the financial balances.

___ I understand that a copy of my insurance card (front and back) will be retained in my client/patient file for billing purposes.

___ I agree that private information may be shared with my insurance carrier for billing purposes.

___ I understand that if I do not want information shared that I may submit specific directions to MethodWorks in writing.

_______________________________________ _____________ _______________

Name of Primary Sponsor/Guarantor SS# Date of Birth

____ ______________________

Name of Primary Insurance Carrier Policy #

_______________________________________ _____________ _______________

Name of Secondary Sponsor/Guarantor [if none, write N/A] SS# Date of Birth

____ ______________________

Name of Secondary Insurance Carrier Policy #

____

Medicare/Medicaid Identification # [if none, write N/A]

___________________________________ ____________________

Client Sponsor's Signature Date

Points of Discussion

Prior to your initial meeting with your BCBA, consider the following questions:

Areas of Concern

1. What led you to seek out ABA services?
2. What would you like to see change?
3. If we are successful, how will things look? What would someone see your child doing? What would change within the family? How would someone know the changes were occurring? What behaviors would let them know the changes were happening?

Areas of Strength

1. In terms of your child's behaviors, what would you want to keep the same?
2. What about your family life would be unchanged by a successful intervention?

Family Life and Values

1. Are there things you'd really like to be able to do together as a family that you are not able to currently do together?
2. When you think about a child being a "good kid", what types of things does that child do well?
3. What types of things are important to you as a family?
4. If someone were to compliment your family, what would they be likely to mention?

Activities and Engagement

1. What things does your child like to do?
2. What things does your child not like to do?
3. What activities do you currently enjoy or did you once enjoy doing with your child? 4. What activities do you enjoy doing with your other children? With friends or other family members?
4. What activities does your family currently like to do together, or did they used to enjoy doing together?

Social Communication

1. Does your child currently approach people to play or interact? What does it look like?
2. If you want to interact or play with your child, what do you do?
3. If your child is struggling with a task, what do they do? What does this look like?

Goals and Priorities

1. In terms of your child, what is most important to you right now?
2. In terms of family life, what is most important to you right now?

Other

1. What would you like us to know about your child or your family?
2. What do we need to understand to be able to design an intervention that will work well for your particular family?