Dear Parent/Guardian,

It is our pleasure to welcome your family to Reach. As we initiate services please do not hesitate to contact us with any questions you may have along the way. You are welcome to call at any time and speak with our office manager or to contact your Clinical Supervisor/BCBA directly with specific questions relating to your child's programmatic needs. You may also find helpful information on our website at www.reachohio.com.

Please find below a list of documents that must accompany your application for services. Once we receive your completed application and all required documents we will review your child's file and contact you regarding the next steps of the intake process. We can accept these documents via mail, email, or fax. If you have any additional questions regarding the application or required documents please do not hesitate to contact us.

- Proof of Address (e.g.: utility/cable bill)
- Copy of Health Insurance Card (if applicable)
- Copy of most recent IEP
- Copy of most recent ETR
- Copy of Evaluation Report showing Autism diagnosis
- Copy of parent/guardian drivers license/state ID card
- Completed Autism Scholarship Application (if applicable)
- Homeschool Notification Form (if applicable)
- All completed and signed documents included in this packet

Sincerely,

Reach Administration
4015 W Dublin Granville Rd.
Dublin, Ohio 43017
P: 614-451-4465
F:866-520-7475
reach.admin@reachohio.com
www.reachohio.com

Today's Date _____/_____/_____

Application for Clinic and Home Based ABA Services

Child's Name _____ DOB ____/_____/____ Age: _____ Sex: M ☐ F ☐

Parent/Guardian Name: _____ Email Address: _____

Home Address: _____ Telephone Number:_____

Emergency Contact Name:_____ Telephone Number:_____

Child's Primary Diagnosis: _____ Age of diagnosis: _____

Child's Primary Care Physician:_____ Telephone Number:_____

School District of Residence _____ Name of Current Educational Program: _____

County of Residence: _____ Name of current Service Coordinator:_____

Do you currently use the Autism Scholarship? _____ If yes, name of current provider?_____

Date of last ETR meeting with school district:_____ Date of last IEP meeting:_____

Insurance Information

Primary Health Insurance Co (Please include a copy of the front and back of your card):_____
Plan Name: _____ Member I.D. Number: _____
Address: _____Group Number: _____
Policy Holder Full Name: _____ Effective Date: _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F Child's Social Security Number: _____

Release of Medical Information: I authorize the release of any medical information, by Reach Educational Services or its agents, in order to process medical claims with my insurance company. I authorize a copy of this authorization to be used in place of the original and request payment of benefits either to myself or to the above provider who acquires assignment. I acknowledge that I am financially responsible for payment, including any unpaid deductible, copay or coinsurance balances, or amounts not covered by my insurance policy.

Parent/Guardian Signature: _____ Date: _____

FAMILY HISTORY

Notate if any family member has had any of the following disorders on the left side of the form by placing an "X" in the appropriate column on the right.

	Self	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Speech Disorders	☐	☐	☐	☐	☐	☐
Behavioral Disorders	☐	☐	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐
Mental Health Diagnosis	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐

Client's Developmental and Medical Information

Pregnancy and Delivery

Length of pregnancy (e.g. full term, 40 weeks, 32 weeks, etc.)?	Mother's age when the child was born?
Childs Birth weight?	Any complications during delivery?

Infancy

During the first 12 months, was your child?

Difficult to Feed	NO	YES	Comments:
Difficult to get to sleep	NO	YES	Comments:
Colicky	NO	YES	Comments:

Difficult to put on a schedule	NO	YES	Comments:
Alert	NO	YES	Comments:
Cheerful	NO	YES	Comments:
Affectionate	NO	YES	Comments:
Sociable	NO	YES	Comments:
Easy to comfort	NO	YES	Comments:
Difficult to keep busy	NO	YES	Comments:
Overactive, in constant motion	NO	YES	Comments:
Very stubborn, challenging	NO	YES	Comments:

Culture and Family Considerations

Are there any ethnic, cultural, and/or religious traditions, beliefs, or values of which you would like us to be aware?	NO	YES	If yes, please explain:
Is there any family responsibility or structure (legal) of which you would like us to be aware?	NO	YES	If yes, please explain:

Health History

At any time has your child had any of the following:

Asthma	NEVER	PAST	PRESENT
Allergies	NEVER	PAST	PRESENT
Diabetes	NEVER	PAST	PRESENT
Epilepsy or seizure disorder	NEVER	PAST	PRESENT
Chicken Pox	NEVER	PAST	PRESENT
Heart or blood pressure problems	NEVER	PAST	PRESENT
Broken bones	NEVER	PAST	PRESENT
Lead poisoning	NEVER	PAST	PRESENT
Head injury	NEVER	PAST	PRESENT
Surgery	NEVER	PAST	PRESENT
Lengthy Hospitalization	NEVER	PAST	PRESENT
Chronic ear infections	NEVER	PAST	PRESENT
Hearing difficulties	NEVER	PAST	PRESENT
Eye or vision problems	NEVER	PAST	PRESENT
Perpetrator or victim of physical or sexual abuse	NEVER	PAST	PRESENT

Allergies

Client's allergies including food, medication, environmental, etc. and/or any dietary restrictions:

Allergen/Restricted Item(s)	**Effect(s)/Reaction(s)**

Related Therapies and Services

Please provide information regarding the services your child is current receiving or has received in the past:

Therapy/Service	**CURRENT Service Provider and Frequency**	**PAST Service Provider and Frequency**
Speech Therapy		
Occupational Therapy		
ABA Therapy		
Music Therapy		
Physical Therapy		
Feeding Therapy		
Psychological		

GENERAL INFORMATION

Please list things that the child seems to prefer. Consider people, toys, activities or behaviors that s/he engages in or with on a frequent basis.

Preferred persons: _____

Leisure Activities: _____

Games or toys: _____

Videos,music:_____

Food, Snacks : _____

Drinks:_____

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

☐ screaming/tantrums	☐ throwing/breaking objects	☐ self-injury
☐ aggression toward other	☐ self-stimming	☐ inattention
☐ hyperactivity	☐ non-compliance	☐ crying
☐ Elopement	☐ Innedible objects in mouth	☐ Vocal Stereotypy

Please describe any additional behaviors of concern:

Informed Consent for Treatment: I agree and consent to participate in behavioral health evaluations and treatment services offered and provided by Reach Educational Services, an outpatient mental health practice. If the client is under the age of 18 or unable to consent to treatment, I attest that I have the legal authorization to initiate and consent for treatment on behalf of this individual. I have reviewed the emergency care information and client rights and responsibilities. A copy of this form will be provided to me upon request.

Parent/Guardian Signature: Date:

Client Medical History and Treatment Release

This form will be provided to emergency personnel in case of emergency.

Client's Last Name:	Client's First Name:	Client's Middle Name:
Date of Birth:	Height: Weight:	Social Security #
Allergies:		
Current Treatment/Medications:		
Special Health Needs:		
Any prior hospitalizations, surgeries, broken bones, recurring/significant illness, etc.:		
Circle all of the following diseases and/or chronic conditions the child has had: Chicken Pox ☐ Asthma ☐ Hearing Problems ☐ Respiratory infections ☐ Infectious Hepatitis ☐ Diabetes ☐ Vision Problems ☐ Urinary Tract infections ☐ Scarlet Fever ☐ Epilepsy ☐ Ear Infections ☐		
Physician Name:	Physician Phone #:	Physician Fax#
Dentist Name:	Dentist Phone #:	Local Hospital Preference:
Medical Insurance Carrier:	Medical Insurance Policy Holder's Name:	Medical Insurance Policy #:

Treatment Release

I certify that I am the legal parent/guardian of the above named client, who attends Reach Educational v Services, and that, in the case of emergency, I give consent for Reach to contact the emergency contacts and medical personnel listed above, and I give consent for emergency medical treatment including: 1) administration of any emergency treatment deemed necessary by any licensed physician, dentist or other health-care provider; and 2) transfer of the client to any hospital reasonably accessible. This authorization does not cover invasive surgery upon the client unless the medical opinions of two licensed physicians concurring on the necessity of such surgery are obtained prior to the performance of such surgery. I understand that this consent is granted until I provide written revocation of such consent.

_____ _____

Signature of Legal Parent/Guardian **Date**

HIPPA (Health Insurance Portability and Accountability Act) CONSENT FORM FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client information will be maintained by Reach Educational Services as described the Notice of Privacy Practices contained in the Compliance Program and in compliance with federal and state regulation. A copy of the Notice of Privacy Practices is available for review at time of intake, any subsequent appointments, or can be requested by contacting Reach at 614-451-4465.

Reach Educational Services reserves the right to release your health care information based upon a decision by your physician for medical emergency situations and, in general, for continuity of care. Disclosure of information may occur with a consent unless it is an emergency situation or for other exceptions as detailed in the General Statute or in 45 CFR 164.512 of HIPAA. We will release your health care information to third party payers in order to receive payment for services. We will use your health care information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it with a signed release of information form.

We reserve the right to: Call you to remind you of your next appointment and/or leave information on your voicemail. Text or email you appointment reminders if your consent is on file (electronic communication policy). If there is anyone that you would like us to share your health information with, other than a provider, agency, and/or school, please list the names below and circle what type of consents you wish to provide.

Name:	Scheduling	Billing/Payments	Daily/ Treatment Progress	Interventions	Diagnostic Information
Name:	Scheduling	Billing/Payments	Daily/ Treatment Progress	Interventions	Diagnostic Information
Name:	Scheduling	Billing/Payments	Daily/ Treatment Progress	Interventions	Diagnostic Information

I have had the opportunity to read, understand, and ask questions about the Notice of Privacy Practices.

_____ I decline to keep the notice _____ I have kept the notice

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Print Name of Client Date of Birth

Electronic Communication Policy

Email offers an easy and convenient way for therapist and client to communicate, but it can also introduce unique challenges into the therapist-client relationship. Below are some guidelines for contacting Reach Educational Services using email:

- For emergencies, consult an emergency room or mobile crisis. Do NOT use email for emergencies!
- Email is not a substitute for an appointment. If you need an appointment, please schedule a session.
- Appropriate use of email can include referrals and appointment scheduling requests.
- Email should NOT be used to communicate sensitive medical information such as: information regarding sexually transmitted diseases, AIDS/HIV, Mental Health, Developmental Disabilities, and/or Substance Abuse.
- Email is NOT confidential. Be aware that if you send emails from your work, your employer may be able to read your email.
- Email is part of your medical record
- Either party can revoke permission to use the email system at any time.

Texting can also introduce some of the same challenges as email:

- Like email, texting is NOT a substitute for an appointment. If you need an appointment, please schedule a session.
- Because phones can be lost or stolen, it is imperative that you do not communicate information of a sensitive nature over text.
- Appropriate use of text is limited to appointment confirmations or appointment/ call requests.
- Clients should not text Reach Educational Services staff.
- Reach Educational Services may use texts or automated phone calls for appointment reminders.

Please initial _____ I have read the above information and understand the limitations of electronic communication. I understand that Reach Educational Services may not be able to communicate with me electronically if there are concerns regarding confidentiality.

Please initial the appropriate lines. Please put N/A or leave blank if you do not wish to have email or text communication:

_____ It is permissible for Reach Educational Services to contact me via email regarding scheduling.
_____ It is permissible for Reach Educational Services to contact me via text regarding scheduling.

Please initial here if it is permissible for Reach Educational Services to forward your information about services, special programs, funding opportunities, special events, and the Reach Educational Services Newsletter:

Client Name

Gaurdian Signature: _____ Date: _____

Email Address: _____ Cell Phone: _____

Preferred Contact Method: _____ OK to leave a message? Yes ☐ No ☐

Photo/Video Release

I understand that photographs and/or videos may be taken as part of my child's client record and are the property of Reach Educational Services. I understand that if I wish for my child's photos/videos to be used for additional purposes (e.g. training, etc.), I must give consent below. I also understand that any consent granted is effective from the date of the signature until I provide written notice of revocation. Any revocation of permission will be in effect for materials produced beyond the date of the revocation, but will not apply to materials produced by Reach prior to the revocation of permission.

Student's full name: _____

_____ I give permission for my child's photos/videos and client information/work to be used for the following purposes (please initial below to indicate consent for each purpose):

_____ **For class, group, or other center wide photos**. Group photos may be displayed in the center, posted on Reach website, used in presentation/marketing /training materials, etc.

_____ **For use within other clients' PECS books or other augmentative communication devices**. Photographs may be displayed for the purpose of allowing other clients to request an interaction with my child.

_____ **For staff training purposes**. Photographs /videos may be used in training Reach staff.

_____ **For parent/professional training/public presentations**. Photographs /videos may be used in training parents and professionals at classes, workshops, conferences, etc., designed to orient audiences to children with autism, evidence-based practices for autism treatment, etc.

_____ **For Reach newsletter purposes**. Photographs/videos, client and parent quotes, client graphs, client accomplishments, client school or artwork, etc., may be used in the Reach electronic newsletter. These newsletters may be posted on the Reach website.

_____ **For volunteer/intern projects** Photographs/videos, client and parent quotes, client graphs, client accomplishments, client school or artwork, etc., may be used by interns and volunteers as part of educational or community program requirements.

_____ **For marketing, fundraising, or advertising purposes**. Photographs/videos, student and parent quotes, client graphs, client accomplishments, client schoolwork or artwork may be used in brochures, faxes electronic media, slideshows for public presentations, donor appreciation projects, the Reach Educational Services website, etc. I do NOT give permission for my child's photos/videos/etc. to be used for purposes other than client records.

Parent/Guardian Signature: _____ **Date**:_____

TRANSPORTATION SERVICES WAIVER AND RELEASE

REACH EDUCATIONAL SERVICES, LLC

I ("Responsible Party") hereby request transportation services from Reach Educational Services, LLC ("Provider") for _____("Student") to be transported to and from activities in which Student is enrolled with Reach Educational Services, LLC or Reach Therapy Services, LLC ("Transportation Services").

Information about the Transportation Service Provided:

Provider will provide transportation to and from activities in which the Student is enrolled with the Provider in vehicles owned and insured at standard rates by Provider. All vehicles will be operated by Provider's staff. Provider will take reasonable efforts to ensure that staff is licensed to operate a motor vehicle while providing Transportation Services for Provider and that all vehicles are maintained in safe, working order. Reasonable efforts do not include an affirmative duty to investigate its staff without cause, inspect vehicles outside of their ordinary maintenance or alert schedule, or take remedial action not recommended by a qualified mechanic. It is the responsibility of each Responsible Party to conduct his or her own due diligence as to whether the Transportation Services are acceptable for the Student and to the Responsible Party.

Authorization and Acknowledgement:

I authorize Provider to provide Transportation Services for the Student by and through Provider's staff. I understand that the vehicle is not equipped with special restraints. Student is expected to follow all applicable laws regarding riding in a motor vehicle and is expected to follow the directions provided by the operator. The Student must be able to transfer in and out of a vehicle used by Provider. I recognize that there is risk of injury or loss, including death, related to Transportation Services and accidents that may occur. I acknowledge that Provider is providing these Transportation Services as a convenience to Student and that I am assuming the risk for such services rather than finding alternate transportation services.

I represent that I am the natural or legally appointed guardian of the Student and am authorized to waive liability and release claims on behalf of Student and for all claims arising out of injury or loss to or of the Student.

Waiver of Liability:

In consideration of the Transportation Services provided, I, for myself, the Student, and each of our assigns, heirs, executors and administrators, and beneficiaries, release and forever discharge Provider, together with its agents, officers and employees, from any claim that I might have or that could be brought on behalf of

Name of Student _____

_____
Signature of Responsible Party

_____
Date

_____
Relationship to Student

Permission for Child Pick-Up

Reach only allows parents, legal guardians, or people designated by the parent(s) or legal guardian(s) to pick the student up from the center. Indicate below if you wish to give permission for someone other than the parent/guardian to pick up the client from the center. The designated person may be asked to show picture identification when s/he arrives to pick up the child. Any permission granted for child pick-up will remain effective until Reach is notified in writing that below listed person(s) are no longer permitted to transport the child from the Reach premises.

_____ has my permission to pick up my child,
(Name of person transporting Child)

_____ from Reach Educational Services Clinic premises.
(Child's Name)

_____ _____
(Parent/guardian signature) (Date)

_____ has my permission to pick up my child,
(Name of person transporting Child)

_____ from Reach Educational Services Clinic premises.
(Child's Name)

_____ _____
(Parent/guardian signature) (Date)

Home Therapy Preparation and Safety Checklist

Requirement	Initial
A designated space or room for therapy to occur is available ?	
Any pets in the home are safe and not aggressive?	
Therapy space can be kept reasonably clean and clutter free?	
Siblings and pets will be supervised to prevent session interference?	
Dangerous and/or sharp objects are not accessible to children?	
Fire alarms in working order?	
Carbon monoxide detectors in working order?	
Electrical outlets protected?	
First aide resources are available?	
Small objects that pose a choking hazard will be removed?	
Hazardous chemicals/materials are not accessible?	
Parent/guardian or child care provider will be home during the session?	
There will be no illegal activity or items in the home?	
Fire extinguisher available?	
Sessions will be conducted in a room that has egress in case of fire?	
There will be adequate lighting in the room necessary to conduct therapy?	
There will be operational plumbing/heating/cooling available?	
There is no pest control problem in the home?	

_____ _____

Parent/Caregiver Signature Date

Client Payment Policies
(Home ABA Clients/Insurance Funded)

Thank you for choosing Reach Educational Services for your services. We are pleased to participate in your care and look forward to establishing a lasting relationship as your primary provider of behavioral services. As part of this relationship, we wish to establish our expectations of your financial responsibility. Please read our policies, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Payment policies for diagnostic, therapeutic, and ABA therapy services
    a. Payments are due in accordance with insurance policies and are billed on a fee for-service basis.
    b. For diagnostic and therapeutic services, payment or copayment amounts are due at the time of services. We accept cash, checks, or credit cards.
    c. For ABA therapy services, payment or copayment amounts are due weekly on the Wednesday following the prior week of service, unless the insurance company requirements are different. Payments are due upon receipt of statements; late fees will be charged. We accept cash, checks, or credit cards.
    d. Payments are to be delivered to the clinic office manager.
    e. When considering your options as to how you are billed, consider receiving invoices via email as it is the most efficient way for us to get them to you.
    f. *Insurance Payments*
        i. It is important for clients to be informed consumers, who understand the specifications of their insurance policies (e.g. coverage, referral/authorization requirements, etc.). The client's health insurance policy is a contract between the client and her/his Health Insurance Company or employer. It is the client's responsibility to know if her/his insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our providers participate.
        ii. Clients must present a current insurance card if a new card has been issued and/or if there are any changes to their coverage. As a courtesy to our clients, Reach Educational Services will bill your insurance company directly for behavioral health services rendered, provided we are credentialed with your insurance company for the specific service. If problems arise regarding coverage issues, we will attempt to work with the client's insurance company to help resolve them prior to making it the client's responsibility. However, clients are ultimately financially responsible for payment of behavioral health services rendered.
        iii. If you do not present a current insurance card, you will be responsible for payment at the time of your visit. You will receive reimbursement from Reach Educational Services if your insurance pays the claim at a later date. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicaid consider some services to be "noncovered," in which case you are responsible for payment in full.
        iv. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
        v. According to Ohio law, insurers are required to pay a properly submitted claim within 30 days. You have a responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days, the balance will be transferred to your account and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed. If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.
        vi. Reach Educational Services contracts with many insurance plans. Before your appointment, please confirm that we are considered in-network and the services are covered under your plan. If we are considered out-of-network, you will be billed for the cost of care.

vii. If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith.

viii. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

g. Attendance and Missed Appointments
   i. Clients and families are expected to arrive 5-10 minutes before their scheduled appointment. A parent/guardian must remain with the client until the client is in the therapist's care. Ii.
   ii. Clients that are more than 15 minutes late for an appointment will be charged the full-rate of the session and/or may need to be rescheduled. Session that start late may not be billable to insurance. iii.
   iii. Clients should call the office as soon they know they need to cancel a visit. Appointments canceled with less than 24 hours notice may be charged a $60/hour fee. iv.
   iv. Clients who do not notify Reach Educational Services when they need to cancel an appointment will be charged a $60/hour No Show Fee.

h. Chronic Absenteeism and Referral Policy
   i. Because the regular attendance of our clients is so important to the continuity and quality of care that we provide, clients and families who chronically cancel or miss their appointments/sessions and make no attempt to reschedule will be notified that they can no longer schedule appointments with Reach Educational Services. At this point, a client will be referred to another provider for services.
   ii. Reach Educational Services reserves the right to refer families to another provider when there is chronic absenteeism.
   iii. Before being referred to another provider, the family/client will receive written notification that their chronic absenteeism or tardiness has been noted and that it is impacting the services provided. Reach does not discriminate based on sex, gender, race, religion, national origin, disability, or sexual orientation. If they continue to miss or cancel appointments, they will be referred to another provider.

I have read and understand the Reach Educational Services Autism Clinic's client payment policies and agree to abide by its guidelines.

_____ _____

Name of Child/Client Client Date of Birth

_____ _____

Parent/Guardian/Responsible Party Signature Date

ABA Treatment Agreement and Consent Form

This document contains important information about Reach Educational Services (Reach) applied behavior analysis (ABA) professional services and practice policies. It is important that you read through this information carefully and ask questions for clarification at any time. When you sign this document, it will represent an agreement between you and Reach to provide ABA services. You, the consumer, reserve the right to withdraw at any time from these services. Again, please feel free to contact Reach with any questions or concerns about Reach's ABA Services at any time.

Services Offered

Reach abides by the Behavior Analyst Certification Board Guidelines for Responsible Conduct

- Admission into ABA services will be available to children, adolescents, and adults with or without a diagnosis based on the need/desire to modify established behaviors. Certain provisions may apply in regard to diagnosis if someone is seeking funding for the service through a third party, such as private insurance or Medicaid.
- When needed, Reach will provide the client/family with contact information for other professionals who may be better able to assist with the needs of the client if Reach is unable to meet specific treatment needs.
- Services will focus on the development and implementation of a functional behavior assessment and an ABA treatment plan. ABA services will be provided by a Board Certified Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst (BCaBA) or a highly trained Behavior Specialist under the supervision of a BCBA.
- Reach provides ABA services based on the client's current level of individualized needs. The treatment plan will structure antecedent and consequence based strategies that are skill based, functionally equivalent, and non-aversive.
- Behavioral assessment results are available to the client and/or family, and a preliminary treatment plan meeting will be scheduled with the client and ABA professionals to review the proposed service type(s), treatment plan goals and objectives, recommended duration and length of treatment, and a discharge plan for the client.
- Upon discharge, recommendations will be provided as a way to support continued progress or address persisting concerns.
- The contents of both the assessment and treatment plan will be explained to the client and/or family, and Reach staff will willingly answer any related questions about the assessment or proposed service. Reach understands that this information is confidential, and will abide by established confidentiality policies and procedures.
- In addition to direct ABA treatment, ABA services also include training and ongoing consultation in the principles of applied behavior analysis as they pertain to the client's treatment plan with family, educators, and any related service providers.

Assessment, Preparation, and Participation

It is important for any individual to be able to perform at their best during an assessment. Please let the Reach ABA office know of any illness or changes in medication or diet that may necessitate an assessment to be rescheduled. Reach believes in non-aversive, trauma-informed care using an integrated treatment approach to create a positive learning experience for any individual. Thus, Reach also asks that our clients and/or families share information about an individual's preferences, dislikes, and needs that may arise during a clinical assessment. An initial assessment may be conducted in order to make recommendations, but the complete assessment process may take 15-20 total hours, or possibly longer, depending on the specific assessment procedures needed.

Additionally, parent/caregiver participation is an expectation of service. Participation may include team meeting, data collection, and implementation and involvement in the implementation of recommended strategies. If there is a lack of involvement, Reach reserves the right to reconsider the appropriateness of service. Team meetings will focus on progress monitoring, level of service needed, and barriers in treatment as a way to strive toward positive results.

Appointments

Reach's ABA staff is committed to providing consistent, reliable service as scheduled and agreed upon by the client/family. Reach proposes a preliminary set of hours for ABA services within the initial treatment plan, taking into consideration medical necessity (physician recommendation or prescription) and the results of the behavioral assessment. A monthly or weekly schedule of service will be worked out between the client/family and Reach staff assigned to the case. However, any party may cancel or reschedule session(s) previously scheduled, at no cost to the client.

Reach understands that circumstances, such as illness or family emergency, may arise which necessitate the occasional cancellation of appointments. To avoid any misunderstanding, Reach's policy is for a client or family to contact the assigned behavior specialist/analyst directly to cancel or re-schedule session(s). Excessive cancellations by a client/family may result in termination of services, as consistency of the delivery of services as proposed in a treatment plan is critical. Reach does ask that you attempt to give at least 12 hours of notice when canceling or rescheduling an appointment.

Communication

Reach is committed to responding to any questions or comments regarding ABA Services in a timely manner. The Behavior Specialists, Behavior Analysts, and ABA Program Managers are committed to providing the best quality service to clients, which includes timely, professional communication. The clients will be provided with the telephone numbers and email addresses of those individuals involved in direct treatment service and planning. However, basic information about Reach's ABA Services is available through our website (www.Reach.org). More detailed inquiries (non-case related) and referrals for ABA service should be directed to the ABA Program offices.

Reach does not offer on-call coverage for ABA services and programs on a 24-hour basis. Clients may contact their ABA Program office with questions or comments by telephone or email. Concerns may also be directed to Reach's Director of ABA Services, Director of Quality Assurance, or other identified advocates.

Consent

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 implementation of ABA services.

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

_____
Client Name

_____ _____
Parent/Guardian (if applicable) Date

_____ _____
Reach Representative Date