CLIENT INTAKE FORM

Please fill out this packet as completely as possible. This information will assist in the evaluation process.

NOTE: ALL INFORMATION PROVIDED IS CONFIDENTIAL

DATE: ________________________

THERAPY LOCATION: ____

PERSONAL INFORMATION:

Person completing the Client Intake Form (please print name) _____________________________________

Relation to client: ____

Patient Information:

Client's Name: ____ DOB: __________________

Nickname / Goes by: ____ Gender: _______________

Address: ____

Home Phone: (____)______________________ Alternate Phone: (____)_____________________

School: _______________________________ Grade: ____________________

Responsible Party Information:

Guarantor's: ____ DOB: __________________

Relationship to client: ______________________________________

Address if different than client: ____

Home Phone: (____)______________________ Alternate Phone: (____)_____________________

Preferred Email: ______________________________

Employer: ____________________________________ Phone: (____)_____________________

Emergency Contact Information:

Name: ____ Relationship: ____________________________

Home Phone: (____)______________________ Alternate Phone: (____)______________________

Insurance Information:

Primary Insurance Name: ____

Policy ID #: ______________________________ Group # ____________________

Subscriber's Name: ______________________________ DOB: ____________________

Relation to Client: ______________________________

Secondary Insurance Name: ____

Policy ID #: ______________________________ Group # ____________________

Subscriber's Name: ______________________________ DOB: ____________________

Relation to Client: ______________________________

Services and Diagnosis (Laugh & Learn BCBA will confirm these codes):

Procedure Code	Diagnosis Code	Comments
9171 - Assessment	F84.0	
97153 - Tech Time 1:1	F84.0	
97154 - Social Skills Group	F84.0	
97155- Supervision/Protocol Modifications	F84.0	
97156 - Parent/Caregiver Training	F84.0	
97157 - Group Parent Training	F84.0	
0373T Tech Time 2:1	F84.0	

Family History:

Indicate Parents/Guardians living in the home (Circle One):

Marital Status: Single Married Separated Divorced Widowed Single Cohabitants

If divorced, who has physical custody? ______________________ Is it Full or joint? ______________

Who has legal custody? ______________________________ Is it full or joint? ______________

Mother's Name: ______________________________ DOB: ____________________

Place of Employment: ______________________________ Phone: (____) ______________

Occupation: ______________________________

Father's Name: ____ DOB: ______________________

Place of Employment: _________________________________ Phone: (____)________________

Occupation: _____________________________________

Child is our: Biological_______ Adopted_____ Foster Child______

Siblings:

Name	Age	M/F	Speech, Hearing or Medical Conditions
______________________	_______	______	_____________________________________
______________________	_______	______	_____________________________________
______________________	_______	______	_____________________________________
______________________	_______	______	_____________________________________
______________________	_______	______	_____________________________________
______________________	_______	______	_____________________________________

Medical History:

Primary Care Physician: ________________________________ Date of Last Visit: _____________

Address: ____ Office Phone: ________________

Medical Issues: ____

Medication List: Please list all current medications your child is currently taking, both prescription and over the counter:

Medication	Dosage	Frequency	Route of Administration (Oral, Topical, etc)

Please describe any other operations or medical conditions your child has had that are not listed above:

____

____

Pediatrician Name: _______________________________ Office Phone: (____)_______________

List all doctors your child sees routinely:

____

____

Does your child have any seizure conditions? _____________ Under what conditions: ____________

____

____

Is there any additional medical information that you feel would help with evaluating your child: __________

____

____

Additional Background Information:

Describe your main concerns:

____

____

____

____

When were concerns first noticed: ________________________ By Who? ___________________

What changes in your child's development and/or behavior have you noticed since that time?

____

____

____

____

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____

____

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

____

____

____

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____

AREAS OF CONCERN

_____ Difficulty swallowing
_____ Mouthing objects inappropriately
_____ Excessive drooling
_____ Biting, pinching, etc.
_____ Uses only 1-2 words
_____ Refusal to obey
_____ Echolalia (repetitive speech)
_____ Stuttering
_____ Poor sentence structure
_____ Difficulty answering questions
_____ Numerous ear infections
_____ Misarticulating of words
_____ Seizure activity
_____ Impulsiveness
_____ Difficulty with change
_____ Dislikes being touched
_____ Places self in dangerous situations
_____ Clumsy, trips often
_____ Weakness in arms, legs, trunk
_____ Poor balance
_____ Unable to catch tossed ball
_____ Toe-walks
_____ Spins inappropriately
_____ Difficulty chewing food
_____ Picky Eater
_____ Inappropriate toy play
_____ Does not understand simple directions
_____ Difficulty sleeping
_____Runs from parents, teachers, etc.
_____ Distractibility
_____ Poor/inappropriate eye contact
_____Pronoun misuse
_____ Poor social interaction
_____ Delay in sitting up
_____ No verbal language
_____ Bedwetting
_____ Thumb sucking
_____ Fixates on television/videos
_____ Dislikes malls, shopping centers, etc.
_____ Delay in pulling up, crawling
_____ Poor eye-hand coordination
_____ Unable to ride bicycle
_____ Fear of swings, playground equipment
_____ Increased muscle tone in arms, legs
_____ Lines up objects
_____ Weak hand muscles

AREAS OF CONCERN (continued)

_____ Poor handwriting

_____Poor hygiene

_____Uses one hand more than the other hand

_____ Strong gag reflex

_____ Difficulty climbing stairs

_____ Uncoordinated running pattern

_____ Unable to dress/undress self

_____ Unable to skip or hop on one foot

_____ Cannot feed self independently

_____ Intolerant to textures

_____ Hums to self

_____ Stimming activity/hand flapping

Please provide any additional concerns or information that you feel may be important regarding your child:

____

____

____

____

____

____

____

____

____

Child's Name: ____ DOB: ______________________

Parent/Legal Guardian Signature: ____

Parent/Legal Guardian Printed Name:____

Date Signed: _________________________________

ALLERGY NOTIFICATION

Your child's therapist may utilize examination gloves and various foods during therapy to assess or stimulate certain behaviors. We know some children are allergic to the materials used in examination gloves and may be on specialized diets or have food allergies. Please list any known allergies in the space below. This information will be noted in a prominent place in your child's chart. Please keep your child's therapist informed of any allergic reaction, which is identified in your child over the course of his/her therapy program. Your child's health and safety are of the utmost importance to us.

Please list ANY known allergies:

____

____

____

If your child has no known allergies, please write "NO KNOWN ALLERGIES" in the blank below before signing this form:

____

I have provided the information above to the best of my knowledge at the request of Laugh & Learn and my child's therapist of any change in the status of the above information.

Child's Name: ____ DOB: ___________________

Parent/Legal Guardian Signature: ____

Parent/Legal Guardian Printed Name____

Date Signed: ____________________________

CONSENT TO COMMUNICATE

Child's Name: ____ DOB: _________________

As the parent/legal guardian of the child listed above, I hereby authorize the representatives of Laugh & Learn to discuss any information regarding therapy sessions, progress, treatment plans and scheduling of my child with the following person(s).

AUTHORIZED PERSONS(S)

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

AUTHORIZED PICKUPS

I hereby further authorize the following person(s) to pick up my child from his/her scheduled appointments with Laugh & Learn:

AUTHORIZED PERSON(S):

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

Children will not be allowed to leave with anyone else other than those people listed above. Additional individuals may be added to this list by a parent/legal guardian by personally providing the information to the Center. Upon their arrival at the Center, authorized individuals should present a driver's license or other form of identification.

If no one appears to pick up a child 15 minutes past the appointed pick-up time, Laugh & Learn will contact the parents/legal guardian via telephone. If a parent/legal guardian is unreachable, the emergency contact will be called. The Laugh & Learn staff member will wait with the child until an authorized person arrives to pick up the child. In case of an emergency, parents may give verbal permission for someone else not listed on the authorized list to pick up their child. If no one has arrived to pick up a child at the time of the Center's closing, and no one on the emergency contact can be reached, the clinical staff member assigned to the child will contact Child Protective Services.

Children must arrive on-time and should be picked up immediately at the end of the session. This ensures appropriate services are delivered and clinician's time is effectively and efficiently utilized. Therapists will be ready to meet children at the drop off area. Parents/clients should contact the Center if they cannot meet the scheduled time for arrival or departure. This will ensure that staff has enough time to prepare to receive the child with minimal disruption to the other students who have already started the session. Our center numbers are listed below:

Brighton – 810.775.3300
Flint – 810.545.7230

Appointments

Except for rare emergencies, we will see you (or your child) at the time scheduled. We understand that circumstances (such as an illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, to avoid any misunderstanding, we ask that you speak to us personally and give us as much notice as possible to cancel or reschedule. This will allow us to offer your time to another person. You may be charged the standard hourly rate for appointments unkept or cancelled with less than 48 hours advance notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges.

Child's Name: ____ DOB________________________

____ ___________________________
Signature of Parent/Legal Guardian Date

____
Printed Name of Parent/Legal Guardian

MEDICAL RECORDS RELEASE REQUEST

FAX: 810.510.0988

I hereby authorize and request that____

release a complete copy of all medical records that pertain to care for

(Client name): ____, at your facility.

I, (parent/guardian name) ___________________________ request the release information to Laugh & Learn Therapy for the purpose of continued medical care.

This request is valid for 30 days from the request. Please respond accordingly.

Client Name (print clearly): ____

Signature of Parent/ Legal Guardian: Date:

__________________________________ ___________________

If you have any questions, please contact our facility at:

Brighton: 810.775.3300

<u>NOTICE OF PRIVACY RIGHTS</u>

How your health Information May Be Used:

<u>To Provide Treatment</u>

We will use the client's health information within our office to provide them with the best services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care between clinical and business office staff. In addition, we may share health information with physicians, referring health care professionals, and other healthcare personnel providing treatment to the client.

<u>To Obtain Payment</u>

We may include health information with an invoice used to collect payment for treatment received or it may be included with an insurance form filed for the client in the mail or sent electronically. We will work only with companies who share our commitment to the security of the client's health information, meaning they are compliant with HIPAA regulations.

<u>To Conduct Health Care Operations</u>

Your health information may be used during performance evaluations of our staff. Health information may be included in peer review for our employees and associates. It is also possible that insurance companies or government appointed agencies, as part of their quality assurance and compliance reviews will disclose health information during audits. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

<u>Patient Reminders</u>

Because consistency is very important in your therapy, we may remind you of scheduled appointments or evaluations. We believe in consistency of care and will inform you of treatment options or services that may be of interest to you and your family. These communications are an important part of our philosophy of partnering with our clients to be sure they receive the best care we can provide. These may include postcards, letters, telephone reminders or electronic reminders such as email (unless you inform our office that you do not want to receive these reminders).

<u>Abuse or Neglect</u>

We will notify government authorities if we believe a client is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgement, when we believe we are specifically required or authorized by law, or with a client's parent or legal guardian's agreement.

<u>Public Health and National Security</u>

We may be required to disclose to Federal officials or military authorities' health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment, or medical device.

PATIENT BILL OF RIGHTS & RESPONSIBILITIES

Restrictions
You have the right to request restrictions on certain uses and disclosures of your child's health information. Our office will make every effort to honor reasonable restriction requests from our clients.

Confidential Communications
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your child's health information privately, with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Health Information
You have the right to read, review and copy your child's health information including the chart and billing records. If you would like a copy of the health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend The Health Information
You have the right to ask us to update or modify your child's records if you believe their health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information records in question were not created by our office, are not part of our records, or if the records containing the health information are determined to be inaccurate or incomplete.

Documentation Health Information
You have the right to ask us for a description of how and where your child's health information was used by our facility for any reason other than for treatment, payment, or health operations. Please let us know in writing the time period of which you are inquiring. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your child's health information and to provide to you this notice. We are required to practice the p policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. If we change our privacy practices, we will be sure all of our clients receive a copy of the revised notice.

You have the right to express complaints to us or the Department of Health and Human Services if you believe your rights have been compromised. We encourage you to express any concern you may have regarding the privacy of your child's information. Please let us know your concerns or complaints in writing.

Laugh & Learn is dedicated to helping children and adolescents with autism spectrum disorders (ASD) and other developmental disabilities achieve their potential in family, community and social life. We care about the dignity and welfare of all who receive services from us. Although these rights have been written for the patient, in most cases they also apply to the patient's parents or legal guardians. The center expects all staff, patients, families, and visitors to always act in a reasonable and responsible way. If you have a concern about any of these rights or responsibilities, you may discuss it with the staff involved, their supervisor, the clinical director, your physician or social worker.

A Child's Rights
While you are at Laugh & Learn, you have the right:

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES (continued)

- To always be politely treated by a staff member.
- To keep your health information private.
- To have safe care that is not needlessly hurtful.
- To have your care told to you in a way you understand.
- To use a translator to tell you about your care in a language you understand.
- To understand your options and to make the best choices for your care.

A Parent's/Legal Guardian's Rights

As a parent/legal guardian of a child at Laugh & Learn, you have the right:

- To receive a complete copy of your child's information, including assessment, treatments, and prognosis (predicted chance of recovery).
- To stop, ignore or refuse treatment for your child to the extent it is allowed by law. If you do this, Laugh & Learn may stop treating your child.
- To receive a description of all the services and charges listed on your child's bill, regardless of how you are paying for it.
- To expect that the Laugh & Learn staff talk with you regularly to understand your family's needs; recognize developmental goals; and to understand when treatment is right for your child's age.
- To be involved in your child's care and use the Laugh & Learn resources to understand your child's condition.
- To discuss concerns with your child's staff. If you still have concerns, you can request a meeting with the clinical director to discuss them.

Parent/Legal Guardian Responsibilities

As a parent/legal guardian who is dedicated and motivated to assist your child, you have a responsibility:

- To give the staff your child's complete, correct medical history and to update this information with any changes.
- To follow the treatment plans developed by the Laugh & Learn staff.
- To be responsible for your actions and any effect it may have on your child if you refuse treatment or do not follow the staff's directions.
- To pay for services as soon as possible.
- To be respectful of other children, families and the Laugh & Learn staff, including noise, the amount of visitors and other's personal property.

CONSENT TO EVALUATE AND TREAT
PRIVACY NOTICE ACKNOWLEDGEMENT

I, the undersigned, am the parent/legal guardian and I authorize Laugh & Learn to perform evaluations, and/or treatment services as necessary and appropriate given the client's diagnosis, abilities, skills, and goals discussed and developed by the client's planning team.

I understand that I must, and do, give my consent to Laugh & Learn to arrange for emergency medical treatment for the child listed below in case of an emergency. I understand that federal law permits Laugh & Learn to release any protected health information necessary about the named client for any such emergency treatment.

I acknowledge that Laugh & Learn has offered me a reviewable copy of the Notice of Privacy Practices and the Patient Bill of Rights and Responsibilities. These notices explain how my protected health information is used and disclosed by Laugh & Learn for treatment, payment, operations, and other uses under Federal HIPPAA and other laws. These notices explain my rights regarding protected health information and what rights I hold as a recipient of Laugh & Learn services.

Child's Name: ____ DOB_________________________

Signature of Parent/Legal Guardian: ____

Printed Name Parent/Legal Guardian: ____

Date Signed: ______________________________________

Photo / Video / Audio Release Form

At Laugh & Learn we are always seeking to enhance the effectiveness of our interventions, our staff's knowledge, and training, as well as to enhance scientific knowledge through research. In doing so, we would like to ask your permission to record your child during sessions for the purpose of evaluating the interventions, educating, and training our staff, and to conduct further research. In addition, some supplies/stimuli such as visual supports are best implemented with actual photos of our clients. If you do not want your child recorded for any reason there is no obligation to agree to your child being recorded. Laugh & Learn will never record your child without your permission.

I, ________________________agree to the recording: video, audio and/or still imagery/photograph of my child, for the purpose of creating materials for my child's program including but not limited to documenting baseline information and visual support systems

I, _________________________, agree to the recording: video, audio and/or still imagery/photograph of my child, for the purpose of training and supervision within the company. I understand that the footage will be used to help train and educate Laugh & Learn staff on intervention procedures.

I, __________________________, agree to the recording: video, audio and/or still imagery/photograph of my child, for the purpose of scientific research. I understand that the footage will only be shown to the researchers for the purpose of collecting data and the identity of the child will not be shared with people outside of Laugh & Learn.

I, __________________________, agree to the recording: video, audio and/or still imagery/photograph of my child, for the purpose of educating researchers, educators, and families at various conferences, trainings, workshops or other educating venues.

I, __________________________, do not agree to the recording: video, audio and/or still imagery/photograph of my child, for any reason and will not consent to the recording or photographing my child by Laugh & Learn staff.

I understand that signing this form is voluntary and that if I decline to sign, it won't' affect the continuation or quality of services provided by Laugh & Learn. I understand that I can revoke this authorization at any time with written notice via email or to the center's physical address.

Child's Name: ____ DOB________________________

Signature of Parent/Legal Guardian: ____

Printed Name Parent/Legal Guardian: ____

Date Signed: _____________________________________

FINANCIAL RESPONSIBILITY

If you have a question or objection to fees assessed, objections or inquiries must be made within 10 days of receipt of the relevant invoice to allow review and consideration. Inquiries regarding invoices over +0 days old will be deemed untimely and payment will be expected for services. If necessary, we may seek assistance from an outside party to collect payment for services. In such cases, any disclosures are limited to the minimum that is necessary to achieve the purpose. Laws and professional standards governing these issues are complex, and it is important that we discuss any questions or concerns that you (or your minor child) may have at our first meeting, and as they may arise in the course of our work together. If any of these types of situations arise, we will make every effort to fully discuss it with you before taking any action, and we will limit our disclosure to what is necessary.

I authorize Laugh & Learn to bill my insurance provider on my dependent's behalf. I accept ultimate responsibility for my account and the amount due for services rendered. I will do everything possible to assist in the collection from my insurance carrier, if applicable.

____ _____________________________
Child's Name (Please Print) DOB

____ _____________________________
Parent/Legal Guardian Signature Date

____
Parent/Legal Guardian Printed Name

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and/or your child/children* may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact our office.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or operations for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of Laugh & Learn's practice.

Following are examples of the types of uses and disclosures of your protected health information that Laugh & Learn is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by Laugh & Learn.

*All references to "you" or "your" refer to both you and your child, if you are a parent or legal guardian of a child or children receiving ABA Services.

Behavioral Care: We will use and disclose your protected health information to provide, coordinate, or manage your behavioral care and any related services. This includes the coordination of management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a health agency that provides care to you. We will also disclose protected health information to other therapists who may be working with you. For example, your protected health information may be provided to a therapist to whom you have been referred to ensure that the therapist has the necessary information to treat you.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services recommended for you such as: deciding of eligibility or coverage for insurance benefits, reviewing services provided to you for necessity, and undertaking utilization review activities.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of Laugh & Learn's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of employees, licensing and conducting or arranging for other business activities.

We will share your protected health information with third party “business associates” that perform various activities (for example, billing or insurance) for Laugh & Learn. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury, or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information during any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We will disclose health information about you when required to do so by federal, state, or local law

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Military Activity and National Security: When the conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military

command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision or protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally- established programs.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization.

Other Permitted and Required Uses and Disclosures That Require Providing you the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You can agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your Lead Clinical Supervisor, BCBA or Behavior Technician may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information.

This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your Lead Clinical Supervisor, BCBA, Behavioral Technician and the Laugh & Learn practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact us if you have questions about access to your clinical record.

You have the right to request a restriction of our protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes of therapy, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restriction to apply.

Your Lead Clinical Supervisor, BCBA and Behavior Technician are not required to agree to a restriction that you may request. If your Lead Clinical Supervisor, BCBA or Behavior Technician does agree to the requested restriction, we may not use or disclose your protected health information in violation of this restriction unless it is needed to provide emergency treatment. Please discuss any restriction you wish to request with your Lead Clinical Supervisor, BCBA or Behavior Technician. You may request a restriction by submitting the request in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to your Lead Clinical Supervisor.

You may have the right to have your Lead Clinical Supervisor or BCBA amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact your Lead Clinical Supervisor if you have any questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints

You may complain to us or to the Michigan Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Director of Business Operations at 810.775.3300. We will not retaliate against you for filing a complaint.