Dr. Ryan - Car Storage Box Contents

All contents of the box are stored alphabetically by form/document title. In the list below they are broken up by category .

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Data Sheet 2

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CHATT Employee Information Form

I9 Form

W4 Form

Family / Insurance / HIPAA Documents (by Filename/Document Title)

Child/Family Information Form

Insurance Verification Form

Notice of Privacy Practices

Receipt of NOPP Form

ABC LOG

Date		Antecedents	Behavior	Consequences
Initials				
How long Behavior Last				
PRN meds if used				
Setting/ Activity		Calming down technique	Or preventive technique	Reinforcer

Date		Antecedents	Behavior	Consequences
Initials				
How long Behavior Last				
PRN meds if used				
Setting/ Activity		Calming down technique	Or preventive technique	Reinforcer

Date		Antecedents	Behavior	Consequences
Initials				
How long Behavior Last				
PRN meds if used				
Setting/ Activity		Calming down technique	Or preventive technique	Reinforcer

CHATT
Childhood Autism Treatment Team

Attendance Policy

1. Once the schedule has been set at each child's house, you are expected to work all shifts. If you are not able to make a scheduled shift for any reason, you are expected to make up all missed hours by the end of the month.

2. If you need to take a day off of work, you must notify the family and senior therapist as soon as possible. You are responsible for finding someone to cover your shift. If nobody is available to cover your shift, you must arrange, with the family, a time when you can make up any missed hours.

3. If you would like to request off of work for a vacation, you must notify the family and senior therapist at LEAST a week in advance. You are responsible for finding another therapist to cover as many shifts as possible. You are also responsible for making up any other hours within the same month, either before or after your vacation.

4. If you miss more than three shifts per month because of illness, you are responsible for obtaining a note from a doctor or other healthcare professional stating your condition and amount of time you will need off of work. You are responsible for making up missed hours before the end of the month, and/or finding another therapist to cover your shifts.

It is your responsibility to make sure that you work all scheduled hours each month. The children really need you to be committed to your job!!

I have read over and understand the CHATT attendance policy. I accept responsibility for each of the areas outlined in the policy, and understand that failure to follow these expectations may result in termination of employment.

_____ _____

Name Date

DATA SHEET PROGRAM: _____
2004 SB

Date	In	Target	success	trial	%	Comments

DATA SHEET

Date	In	Target	success	trial	%	Comments

Program Name:______________________________

Date:______ Initials:______

1.______ ___ 6.______ ___
2.______ ___ 7.______ ___
3.______ ___ 8.______ ___
4.______ ___ 9.______ ___
5.______ ___ 10.______ ___
Percent______%
Notes:

Date:______ Initials:______

1.______ ___ 6.______ ___
2.______ ___ 7.______ ___
3.______ ___ 8.______ ___
4.______ ___ 9.______ ___
5.______ ___ 10.______ ___
Percent______%
Notes:

Date:______ Initials:______

1.______ ___ 6.______ ___
2.______ ___ 7.______ ___
3.______ ___ 8.______ ___
4.______ ___ 9.______ ___
5.______ ___ 10.______ ___
Percent______%
Notes:

Date:______ Initials:______

1.______ ___ 6.______ ___
2.______ ___ 7.______ ___
3.______ ___ 8.______ ___
4.______ ___ 9.______ ___
5.______ ___ 10.______ ___
Percent______%
Notes:

Date:______ Initials:______

1.______ ___ 6.______ ___
2.______ ___ 7.______ ___
3.______ ___ 8.______ ___
4.______ ___ 9.______ ___
5.______ ___ 10.______ ___
Percent______%
Notes:

Date:______ Initials:______

1.______ ___ 6.______ ___
2.______ ___ 7.______ ___
3.______ ___ 8.______ ___
4.______ ___ 9.______ ___
5.______ ___ 10.______ ___
Percent______%
Notes:

Date:______ Initials:______

1.______ ___ 6.______ ___
2.______ ___ 7.______ ___
3.______ ___ 8.______ ___
4.______ ___ 9.______ ___
5.______ ___ 10.______ ___
Percent______%
Notes:

Date:______ Initials:______

1.______ ___ 6.______ ___
2.______ ___ 7.______ ___
3.______ ___ 8.______ ___
4.______ ___ 9.______ ___
5.______ ___ 10.______ ___
Percent______%
Notes:

Date:______ Initials:______

1.______ ___ 6.______ ___
2.______ ___ 7.______ ___
3.______ ___ 8.______ ___
4.______ ___ 9.______ ___
5.______ ___ 10.______ ___
Percent______%
Notes:

Program Name:_____

Date/IN:	1	2	3	4	5	6	7	8	9	10	11	12	13	14

SB 2004

Child's Name:		Therapist:
Date of missed hours:	Shift:	#of hours missed:
Session cancel by:	PARENTS	THERAPIST
Reason for cancellation:	Request off	Sick Doctor's Appt. No Call, No Show
Plan for make up or who filled the shift:		
Date of hours made up: #of hours made up:		

Child's Name:		Therapist:
Date of missed hours:	Shift:	#of hours missed:
Session cancel by:	PARENTS	THERAPIST
Reason for cancellation:	Request off	Sick Doctor's Appt. No Call, No Show
Plan for make up or who filled the shift:		
Date of hours made up: #of hours made up:		

Child's Name:		Therapist:
Date of missed hours:	Shift:	#of hours missed:
Session cancel by:	PARENTS	THERAPIST
Reason for cancellation:	Request off	Sick Doctor's Appt. No Call, No Show
Plan for make up or who filled the shift:		
Date of hours made up: #of hours made up:		

Child's Name:		Therapist:
Date of missed hours:	Shift:	#of hours missed:
Session cancel by:	PARENTS	THERAPIST
Reason for cancellation:	Request off	Sick Doctor's Appt. No Call, No Show
Plan for make up or who filled the shift:		
Date of hours made up: #of hours made up:		

Program_____

Narrative Data sheet

Therapist:_____ Date:_____

Therapist:_____ Date:_____

Therapist:_____ Date:_____

Therapist:_____ Date:_____

Therapist:_____ Date:_____

Percent Table

1		2		3		4	
1	100%	2	100%	3	100%	4	100%
		1	50%	2	66%	3	
				1	33%	2	
						1	
5		**6**		**7**		**8**	
5	100%	6	100%	7	100%	8	100%
4	80%	5	83%	6	86%	7	88%
3	60%	4	66%	5	71%	6	75%
2	40%	3	50%	4	57%	5	63%
1	20%	2	33%	3	43%	4	50%
		1	17%	2	29%	3	38%
				1	14%	2	25%
						1	13%
9		**10**		**11**		**12**	
9	100%	10	100%	11	100%	12	100%
8	89%	9	90%	10	91%	11	92%
7	78%	8	80%	9	81%	10	83%
6	67%	7	70%	8	72%	9	75%
5	56%	6	60%	7	63%	8	67%
4	44%	5	50%	6	54%	7	58%
3	33%	4	40%	5	45%	6	50%
2	22%	3	30%	4	36%	5	42%
1	11%	2	20%	3	27%	4	33%
		1	10%	2	18%	3	25%
				1	10%	2	17%
						1	8%

Program Checklist

Programs															

Program Information Sheet

Program Name:_____
Skill Type :_____

Program Description:

Stimulus (SD)	Response ®	Date introduced	Date Mastered
1.			
2			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Stimulus (SD)	Response ®	Date introduced	Date Mastered
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			

Peer interaction data sheet
Child name_____

Location:_____ Peers attended_____
Start time _____ End time_____ Date_____ Therapist_____

Friendship Skills		Rating of friendship skills			Comments/Observations
Entry levels	Appropriate Greeting	+	-	wp	
Accepting Suggestions	*Incorporating* Other's ideas	+	-	wp	
	Indicates Agreement	+	-	wp	
Reciprocity	Conversation	+	-	wp	
	Activities	+	-	wp	
Sharing	Appropriate sharing/turn taking	+	-	wp	
Avoiding	Seeks solitude appropriately	+	-	wp	
Cooperation	Contributes to common goal	+	-	wp	
	Accepts the rules of the game	+	-	wp	
	Patient	+	-	wp	
	Aware of personal body space	+	-	wp	
	Aware of appropriate touching	+	-	wp	
	Copes with mistakes	+	-	wp	
	Copes with being interrupted	+	-	wp	
	Tells truth	+	-	wp	
	Gives guidance	+	-	wp	
	Gives encouragement	+	-	wp	
	Avoids behaving in a silly manner	+	-	wp	
	Appropriate humorous comments	+	-	wp	
	Appropriate volume	+	-	wp	
Conflict Resolution	Compromise	+	-	wp	
	Avoids aggression	+	-	wp	
	Accepts mistakes of others	+	-	wp	
	Copes with change, new ideas, being interrupted	+	-	wp	
	Does not consciously torment or provoke	+	-	wp	
	Recognizes the perspective of others	+	-	wp	
	Recognition of being unfair	+	-	wp	
	Recognizes Unfriendly acts	+	-	wp	
	Uses verbal persuasion	+	-	wp	
	Avoids physical response	+	-	wp	
	Avoids emotional blackmail	+	-	wp	
	Seeks negotiation	+	-	wp	
	Seeks compromise	+	-	wp	
	Seeks Referee	+	-	wp	
	Forgives	+	-	wp	
Empathy	Gesture	+	-	wp	
	Facial expression	+	-	wp	
	Tone of voice	+	-	wp	
	Recognizes signs of annoyance	+	-	wp	
	Recognizes boredom	+	-	wp	
	Recognizes approval	+	-	wp	
	Recognizes embarrassment	+	-	wp	
	Not possessive of their friend	+	-	wp	
	Inhibits comments that might offend	+	-	wp	
	Apologizes for mistakes	+	-	wp	
	Offers comfort	+	-	wp	
	Ignoring	+	-	wp	
Monitoring	Observing others	+	-	wp	
Eye contact	Social punctuation	+	-	wp	
	Read Facial Expression	+	-	wp	
Imitating	The actions of others	+	-	wp	
Making Innovations	Based on the actions of others	+	-	wp	
Ending	Closure appropriate	+	-	wp	

Sibling interaction Data Sheet

Date_____ Therapist_____ Activity_____

Sibling interaction social skills					Comments/Observations
Appropriate Conversation	Using his or her own words	+	-	wp	
Empathy	Apologizes Appropriately	+	-	wp	
Conflict Resolution	Avoids physical aggression	+	-	wp	
	Does not consciously torment or provoke	+	-	wp	
	Avoids emotional blackmail	+	-	wp	
	Uses verbal persuasion	+	-	wp	
	Accepts mistakes of sibling	+	-	wp	
	Copes with change, new ideas, being interrupted	+	-	wp	
	Recognition of being unfair	+	-	wp	
	Forgives	+	-	wp	
	Compromise	+	-	wp	
Cooperation	Accepts the rules of the game	+	-	wp	
	Appropriate turn taking or sharing	+	-	wp	
	Patient	+	-	wp	
	Aware of personal body space	+	-	wp	
	Aware of appropriate touching	+	-	wp	
	Copes with mistakes	+	-	wp	
	Copes with being interrupted	+	-	wp	
	Copes with losing	+	-	wp	
	Avoids behaving in a silly manner	+	-	wp	
	Gives encouragement	+	-	wp	

Date_____ Therapist_____ Activity_____

Sibling interaction social skills					Comments/Observations
Appropriate Conversation	Using his or her own words	+	-	wp	
Empathy	Apologizes Appropriately	+	-	wp	
Conflict Resolution	Avoids physical aggression	+	-	wp	
	Does not consciously torment or provoke	+	-	wp	
	Avoids emotional blackmail	+	-	wp	
	Uses verbal persuasion	+	-	wp	
	Accepts mistakes of sibling	+	-	wp	
	Copes with change, new ideas, being interrupted	+	-	wp	
	Recognition of being unfair	+	-	wp	
	Forgives	+	-	wp	
	Compromise	+	-	wp	
Cooperation	Accepts the rules of the game	+	-	wp	
	Appropriate turn taking or sharing	+	-	wp	
	Patient	+	-	wp	
	Aware of personal body space	+	-	wp	
	Aware of appropriate touching	+	-	wp	
	Copes with mistakes	+	-	wp	
	Copes with being interrupted	+	-	wp	
	Copes with losing	+	-	wp	
	Avoids behaving in a silly manner	+	-	wp	
	Gives encouragement	+	-	wp	

	Monday	Tuesday	Wed	Thursday	Friday	Saturday	Sunday
7:00 A.M.							
8:00 A.M.							
9:00 A.M.							
10:00 A.M.							
11:00 A.M.							
12:00 P.M.							
1:00 P.M.							
2:00 P.M.							
3:00 P.M.							
4:00 P.M.							
5:00 P.M.							
6:00 P.M.							
7:00 P.M.							
8:00 P.M.							

Session log

Child_____ Date_____ Time _____

_____
_____
_____
_____
_____
_____

Therapist _____

Child_____ Date_____ Time _____

_____
_____
_____
_____
_____
_____

Therapist _____

Child_____ Date_____ Time _____

_____
_____
_____
_____
_____
_____

Therapist _____

SKILL SHEET - DATA SHEET

PROGRAM NAME:

PROGRAM GOAL:

PROGRAM INSTRUCTION:

MATERIALS : NEEDED

STIMULUS	DATE INTRODUCED	DATE MASTERED	DATES CHECKED FOR MAINTENANCE									
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
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11.												
12.												
13.												
14.												
15.												
16.												
17.												
18.												

:00		:15		:30		:45	
1 ____	7 ____	1 ____	7 ____	1 ____	7 ____	1 ____	7 ____
2 ____	8 ____	2 ____	8 ____	2 ____	8 ____	2 ____	8 ____
3 ____	9 ____	3 ____	9 ____	3 ____	9 ____	3 ____	9 ____
4 ____	10____	4 ____	10____	4 ____	10____	4 ____	10____
5 ____	11____	5 ____	11____	5 ____	11____	5 ____	11____
6 ____	12____	6 ____	12____	6 ____	12____	6 ____	12____
%_____		%_____		%_____		%_____	

:00		:15		:30		:45	
1 ____	7 ____	1 ____	7 ____	1 ____	7 ____	1 ____	7 ____
2 ____	8 ____	2 ____	8 ____	2 ____	8 ____	2 ____	8 ____
3 ____	9 ____	3 ____	9 ____	3 ____	9 ____	3 ____	9 ____
4 ____	10____	4 ____	10____	4 ____	10____	4 ____	10____
5 ____	11____	5 ____	11____	5 ____	11____	5 ____	11____
6 ____	12____	6 ____	12____	6 ____	12____	6 ____	12____
%_____		%_____		%_____		%_____	

BACKGROUND INFORMATION DISCLOSURE (BID)

Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. Failure to comply may result in a denial or revocation of your license, certification, or registration; or denial or termination of your employment or contract. Refer to the instructions (F-82064A) on page 1 for additional information. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.

PLEASE PRINT YOUR ANSWERS.

Check the box that applies to you.

- ☐ Employee / Contractor (including new applicant)
- ☐ Applicant for a license or certification or registration (including continuation or renewal)
- ☐ Household member / lives on premises - but not a client
- ☐ Other – Specify:

NOTE: If you are an owner, operator, board member, or non client resident of a Division of Quality Assurance (DQA) regulated facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Name – (First and Middle)	Name – (Last)	Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)	
Any Other Names By Which You Have Been Known (Including Maiden Name)	Birth Date	Gender (M / F)	Race
Address Street, City, State, ZIP Code		Social Security Number(s)	
Business Name and Address - Employer or Care Provider (Entity)			

SECTION A - ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have any criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, local, military and tribal courts? ➢ If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgement of conviction, a copy of the criminal complaint, or any other relevant court or police documents.		
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.) ➢ If **Yes,** list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.		
3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked: ☐ (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.) ➢ If **Yes**, explain, including when and where it happened.		
4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? ➢ If **Yes,** explain, including when and where it happened.		

(continued on next page)

SECTION A (continued)	YES	NO
5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? ➢ If **Yes**, explain, including when and where it happened.		
6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person**? ➢ If **Yes**, explain, including when and where it happened.		
7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? ➢ If **Yes**, explain, including credential name, limitations or restrictions, and time period.		

SECTION B – OTHER REQUIRED INFORMATION	YES	NO
1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? ➢ If **Yes,** explain, including when and where it happened.		
2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? ➢ If **Yes,** explain, including when and where it happened and the reason.		
3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? ➢ *If yes, indicate the year of discharge:* _____ ➢ Attach a copy of your DD214 if you were discharged within the last 3 years.		
4. Have you resided outside of Wisconsin in the last 3 years? ➢ If **Yes**, list each state and the dates you lived there.		
5. Have you had a caregiver background check done within the last 4 years? ➢ If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.		
6. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS designated tribe? ➢ If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.		

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to $1,000.00 and other sanctions as provided in DHS 12.05 (4), Wis. Adm. Code.

SIGNATURE	Date Signed

CHATT/CHAT Employee Information Sheet

	For employee to complete
Employee Name	
Employee Address	
Phone Number(s)	
Email address	
Fax (if applicable)	
Regional Preference for assignment (Counties and portions of counties)	
Farthest willing to drive to a home	
Current role (senior therapist/line therapist)	
Degrees/Licensure/ Certifications/ Specializations/Autism experience	
	For CHAT to complete
Hire Date(s)	
Background Check Date	
Current and Former Clients (non-Insurance)	
Current and Former Clients (Insurance)	

CHATT/Childhood Autism Therapies - Employment Agreement

This is an employment agreement between Childhood Autism Therapies LLC (employer, designated by initials CHAT/CHATT), represented by lead therapist Dr. Colleen Ryan and business manager Mike Rubingh, and _____, (employee). Childhood Autism Therapies is the insurance-billing offshoot of Childhood Autism Treatment Team group.

Duties: As employee of Childhood Autism Therapies, I agree to fulfill all duties of Line Therapist as that role is understood according to the Wisconsin CLTS waiver program for Autism therapy including a) cooperating with supervising psychologist and senior therapists in designing and implementing therapy programs b) following Applied Behavior Analysis (ABA) techniques as primary therapeutic approach c) documenting therapy hours and results according to standard formats--e.g reports, timesheets, etc.--required by State and Insurance administration. d) meeting the job experience and training requirements for the position described and abiding by all rules and requirements of the new WI autism insurance mandate as expressed in the business practices of Childhood Autism Therapies. e) understand and employ proper privacy practices consistent with the therapists role.

At-will employment: This employment will be on an at-will basis. Both parties have the right to terminate this agreement 'at will', with or without cause, at any time without prior notice. This offer of at-will employment is further contingent upon: a) provision of accurate and complete information in an Employment Application and any supporting documentation approved by the Lead Therapist; b) a Successful Comprehensive Background Check per state waiver rules. Lead therapist retains the right to set and modify reimbursement rates as she sees fit based on autism experience and credentials. Using seniority and location-based judgment, CHAT will rank openings and attempt to keep seniors and lines making adequate hours; however, there will be periods of low hours and downtime because of the nature of the business.

Non-compete: As employee I agree not to compete with Childhood Autism Therapies by a) taking a family and/or child served by CHAT and directly or indirectly delivering them to a competing agency or starting a competing agency b) provide confidential CHAT information to a competitor. This non-compete agreement shall continue in effect while I am employed by CHAT for any child, and for 2 years after the end of work with a particular child or family, unless written permission for a non-compete waiver is granted by the lead therapist.

Scope of Employment: I understand that the scope of this employment agreement will be limited by the following parameters a) employment will be part-time hourly employment at a rate of _____ dollars per hour for autism therapy services to the family of _____. I understand that while CHAT makes every effort to keep reimbursement rates consistent with experience levels, Insurers reimburse at differing rates, and the listed rate cannot be guaranteed for future children beyond this agreement b) employment will continue as long as the family agrees, meets waiver requirements, and reimbursement for services provided are continuing from insurance company and/or state payers. If insurance or state reimbursement are terminated, hours already worked will be paid up to the date Childhood Autism Therapies provides notification to the employee. c) employee will bill only as a part-time employee (under 40 hours) for the insurance-funded child or children being he/she serves with Childhood Autism Therapies. This part-time limitation does not apply, however, to any work I'm performing under the 'family-as-employer' and fiscal agent model used by Childhood Autism Treatment Team and I may continue any work I'm performing under that approach as long as the state allows the 'family-as-employer'/fiscal agent model to continue.

Documentation: I understand that I am required to meet federal and state requirements for employment, and will be required to provide proof of both identity and eligibility to work via document confirmation using the standard I-9 form, and will be required to submit to standard federal and state tax withholding per form W-4.

Signature of Employer/Employer Representative:

Date:

Signature of Employee

Date:

CHATT Expense Report - 2012

CHATT senior therapist staff (not line staff) can obtain reimbursement for a limited number of their expenses related to administrative overhead starting in 2012. Please copy this page and use the table below. Pre-approved expenses include the following: reasonable number of copies from a copy shop (include receipt if available), copies of regular forms used for therapy printed at home (paid @ 3-cents per page), reasonable postage or fax charges for timesheets or documents directly related to therapy (include receipt if available).

Travel is included on the timesheet and not on expense reports. All other expenses require a pre-authorization email submitted to Colleen/Mike for approval. Please note that we have several Officejets and a (dated) office copier, so CHATT is able to make bulk copies of any documents that are widely used. Contact Mike about copying/printing, and Colleen about picking up copies (see below).

Date	Description of Expense	Quantity	Unit Price	Line Total
			TOTAL DUE	-

Documents Available from Colleen: In 2012, Colleen will be carrying a large file box with her to therapy appointments (in her car). The most common forms and documents (see below) will be available from her for free. Just ask her (or look in the black file box if she's busy!).

Hiring/Admin Documents

W4	The W4 is the 2012 federal document required to be completed by all employees.
Background Information Disclosure (BID)	The BID form gives the employer permission to run a background check, and is required before working
I9	The I9 form verifies citizenship, and requires additional submission or witnessing of citizenship documents
CHATT Employee Agreement	The employment agreement
CHATT Employee Information Sheet	Provides employee address, email, experience, etc. for admin
CHATT Timesheet	For reporting monthly time, senior staff verify and submit monthly

Therapy Documents:

Initial Treatment Plan	Psychologist creates at onset of therapy for state or insurance
6-month Report/Treatment Plan	Used for meeting state or insurance company 6-month reporting requirements
Basic Progress Note	Used for daily notes in the home

Family Documents:

Family/Child Information Form	Contains address, DOB, contact info, and other essential information about new families.
CHATT Insurance Verification Form	New family confirms/denies private/employer-provided insurance and provides insurance info and signature on file if so.
Notification of Privacy Practices (NOPP)	Legally required by HIPAA, delivered to all new families
Receipt of Privacy Notice Form	New family signs to acknowledge receipt of NOPP
Patient Consent Form	Consent form regarding sharing of information

OMB No. 1615-0047; Expires 08/31/12

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*) _____

Employee's Signature — Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*
Childhood Autism Therapies LLC	

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

Form W-4 (2012)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at *www.irs.gov/w4*. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • *Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.*	B	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child	G	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed *$40,000 ($10,000 if married)*, see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4** Department of the Treasury Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2012

1	Your first name and middle initial	Last name	2 **Your social security number**
	Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5	*Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)*	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2012, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

CHATT Child Information Form

Name of Child_____

Date of Birth _____

Address_____

_____

Telephone numbers (please list all contact numbers and specify type)

_____

_____

_____

Name of mother _____

Name of father_____

Address of nonresidential parent (if applicable)

_____

_____

Names and ages of siblings residing in the home

_____

_____

Please list names and contact information for other family members or caretakers with whom we may be working

_____

_____

_____

CHATT / CHAT Insurance Verification Form

Child Name_____

Parent/Family_____ **Phone#**_____

Parent/Insured Address_____

City_____ **State**_____ **Zip**_____

[ ] My child/family does not have private/employer-provided health insurance. Please bill the autism waiver program directly for therapy services rendered.

[ ] My child/family has private/employer provided health insurance, and I have provided the required information for billing it below. As required by the autism waiver program, please bill my private insurance first, before seeking reimbursement from the waiver.

Parent/responsible party signature_____ **Date**_____

Insurance Payment Authorization/Signature on File Authorization

Primary Medical Insurance Company: _____
(Please include copy/copies of both sides of insurance card with this form, or scan/photo and email to cryan12@msn.com).

I hereby authorize you [insurance company(s)] to pay directly to the below named office benefits due to me out of indemnity under the terms of my policy issued by your company, or benefits due under the terms of any separate service and payment agreement negotiated between [insurance company(s)] and below named office(s).

Childhood Autism Treatment Team (CHATT) DBA Childhood Autism Therapies LLC
Director: Colleen Ryan, PhD. Business Manager: Mike Rubingh.
(1) N1563 County Rd H, Palmyra WI 53156. (2) 106 Main St. Palmyra WI 53156.
Phone: 262-370-7744, Billing Phone: 262-370-5527, Fax: 262-495-8689

I authorize the use of this form for any current and future medical insurance submissions, with payment made directly to the doctor/doctor's business. I authorize the use of this form for any release of information required by CHATT/CHAT. I permit a copy of this to be used in place of the original. Payment by insurer(s) of the amount billed by CHAT for therapy, in whole or part, shall be considered the same as if paid, by your company, directly to me (the insured). I submit the following info necessary for insurance billing.

Patient Name:	Patient DOB:
Insured Person Name:	Insured DOB (if different):
Insurance ID#:	Insurance Policy#:
Employer or School Name:	Insurance Group#:

1. I understand I am ultimately responsible for payment in full for services provided by the therapists of CHAT. I authorize CHAT to act as my agent in helping me obtain payment from my insurance carrier(s). Eventual reimbursement or coverage will be determined by your insurance carrier.
2. I understand that CHAT, as a typical provider may bill me for any co-pays and deductibles that are not paid by insurance or reimbursed by the state, unless expressly forbidden by the waiver program. If I decide voluntarily to end waiver eligibility, I will be responsible for any co-pays and deductibles not paid by insurance or the state that are due to CHAT for services provided. I will inform CHATT of any insurance changes or job changes that may affect my insurance coverage so the best response ensuring therapy continues can be made.

I agree to the above billing policies and authorization for billing

Patient _____ Date_____

Parent or responsible party_____
Relationship to patient_____

Childhood Autism Treatment Team / Childhood Autism Therapies
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU 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 Privacy Officer who is Mike Rubingh, 262-370-5527

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and 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.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, 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 your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office 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 our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, 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 transcription services) for our practice. 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.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

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 a 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.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of 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 may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

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.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate 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 services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of 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.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

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. Please understand that we are unable to take back any disclosures already made with your 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 have the opportunity to 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 physician may, using professional judgement, 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.

2. 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 physician and the

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: psychotherapy notes; 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 our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your 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 treatment, 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 restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **emailing restriction request to cryan12@msn.com**

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 our Privacy Officer.

You may have the right to have your physician 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 our Privacy Officer if you have 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, for a facility directory, 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 after April 14, 2003. 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.

3. COMPLAINTS

You may complain to us or to the Secretary 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 Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Mike Rubingh** at (262)370-5527 or cryan12@msn.com for further information about the complaint process.

This notice was published and becomes effective on **1-1-2011.**

Childhood Autism Treatment Team / Childhood Autism Therapies

Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 1-1-2011

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/therapist on _____(date) and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

  _____

- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):

  _____

Signature of Employee Completing Form: _____

Date Signed: _____