ACCENTRA
Behavioral & Educational Services

NEURODEVELOPMENTAL HISTORY QUESTIONNAIRE

****Please provide all records that pertain to your child's problem (health and school)**

Today's Date:	Patient's Birth Date:
Patient's Full Name:	Nickname:
Parent/Guardian:	2nd Parent/Guardian:
Relation to Patient:	Relation to Patient:
Address:	Address:
City/State/Zip Code:	City/State/Zip Code:
Phone: Home or Cell	Phone: Home or Cell
Email address:	Email address:
Phone: Work	Phone: Work
Current status of parents: (circle) married separated divorced single other	
Other adults in household:	

Please list any doctors or specialists you have seen related to your concerns.

Name of Doctor/Specialist	Type of Specialist	Address
	Primary Care	

Please describe the problem that led to asking for this evaluation/consultation.

_____

_____

_____

When did the problem start? _____

Does the problem occur at a certain time? (When?)_____

How did the problem start? _____

Where does the problem occur?_____

How severe is the problem?_____

What makes the problem better?_____

What makes the problem worse?_____

What other signs or symptoms do you see?_____

ALLERGIES:

List any medication allergies:	**None:**
Problems the allergy causes:	
Other unusual reactions to medications:	
List other allergies:	**None:**

BIRTH:

Weeks Gestation:	**Birth weight:**	**Length of Labor:**
Mother's age at delivery		**Father's age at delivery**
Birth Hospital:		**City/State:**

Please tell us if there were any problems during pregnancy or after birth.

Yes	**No**	**Pregnancy & Birth**	**Brief Description**
		Illness	
		Medication Taken	
		Low iron	
		Bleeding	
		Smoking	
		Alcohol or Drug Use	
		Trouble gaining weight	
		Vaginal delivery	
		Cesarean section	
		Prior miscarriage/abortion	
		Trouble during labor	
		Low Apgar scores	
		Trouble with delivery	
		Trouble in the nursery	
		Home with mother	
		Neonatal Intensive Care	How long?

DEVELOPMENT:

What do you enjoy about your child? What does your child do well?

DEVELOPMENTAL AND BEHAVIORAL CHALLENGES

Below you will find a list of possible areas of development or behavior that may be of concern to you.

Please check one box to the right of each of item.	Never	Some-times	Often	Very Often
These items are for children of all ages:				
1. Loss of developmental skills				
2. Trouble feeding or eating				
3. Trouble making sounds or talking				
4. Trouble understanding				
5. Trouble using his/her hands				
6. Trouble moving, rolling, sitting, walking				
7. Trouble interacting with adults				
8. Trouble figuring out things				
9. Trouble feeding self, dressing, bathing, or toileting				
1. Poor eye contact				
2. Not pointing or using gestures to communicate needs or interests				
3. Lack of interest in interacting or making friends with other children				
4. Failure to seek praise for accomplishments or to be proud				
5. Failure to be tuned into others' feelings or emotions				
6. Failure to take turns				
7. Delayed or complete lack of talking and/or understanding				
8. Repeating back what has just been said instead of answering				
9. Reciting language memorized from TV or movies				
10. Lack of pretend play				
11. Does not play with toys the way they were made or stacks or lines up objects instead of playing with them.				
12. Trouble playing like other children his/her age				
13. Restricted interests that are overly intense or focused				
14. Inflexible adherence to specific routines or rituals that have no real purpose				
15. Repetitive movements like finger flicking, hand flapping, rocking, spinning, pacing, head banging, or toe walking				
16. Preoccupation with parts of objects like spinning wheels or opening and closing doors				
These questions are for children 3 years old and up:				
1. Fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
2. Has difficulty sustaining attention in tasks or play activities				
3. Does not seem to listen when spoken to directly				

Please check one box to the right of each of item.	Never	Some-times	Often	Very Often
4. Does not follow through on instructions and fails to finish schoolwork, chores.				
5. Has difficulty organizing tasks and activities				
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
7. Loses things necessary for tasks or activities at school or at home (e.g. toys, pencils, books, assignments)				
8. Is easily distracted by extraneous stimuli				
9. Is forgetful in daily activities				
1. Fidgets with hands or feet or squirms in seat when sitting still is expected				
2. Gets up from seat when remaining in seat is expected				
3. Excessively runs about or climbs when and where it is not appropriate. Older individuals may feel very restless.				
4. Has trouble playing or doing leisure activities quietly				
5. Is "on the go" or often acts as if "driven by a motor				
6. Talks excessively				
7. Blurts out answers before questions have been finished				
8. Has trouble waiting one's turn				
9. Interrupts or intrudes on others				
1. Frequent temper tantrums				
2. Excessive arguing with adults				
3. Active defiance and refusal to follow requests and rules				
4. Deliberate attempts to annoy and upset people				
5. Blaming others for mistakes and misbehavior				
6. Often being touchy and easily annoyed by others				
7. Frequent anger and resentment				
8. Spiteful attitude and revenge seeking				
9. Getting suspended from school				
1. Excessive anxiety or worry about a variety of events and situations. "Excessive" can be interpreted as more than would be expected for a particular situation or event.				
2. Excessive fears				
3. Afraid to separate from caregiver				
4. Feeling wound-up, tense, or restless				
5. Easily becoming fatigued or worn-out				
6. Concentration problems				
7. Irritability				
8. Significant tension in muscles				
9. Difficulty with sleep				
10. Is bullied				
1. Seems depressed				
2. Seems sad				
3. Seems irritable				
4. Loss of interest in friends, play or school activities				
5. Not having as much fun as in the past				
6. Significant weight loss or weight gain or not gaining weight as expected				
7. Not sleeping enough				

Please check one box to the right of each of item.	Never	Some-times	Often	Very Often
8. Sleeping too much				
9. Refusing to go to school or missing school				
10. Feels worthless				
11. Feels guilty about things that he/she should not feel guilty about				
12. Can't concentrate or make decisions				
13. Has thoughts of death or hurting self				
These are questions for 6 years old and up:				
1. Trouble learning to read				
2. Trouble learning to write				
3. Trouble getting thoughts on paper				
4. Trouble learning math				
1. Fear of getting dirty or contaminated (impurity, pollution, badness)				
2. Worrying about whether has forgotten to do something				
3. Intense need to have or put things in a certain order				
4. Aggressive or frightening impulses to do things				
5. Recurrent sexual thoughts or images				
6. Excessive washing/cleaning				
7. Excessive or repeated counting				
8. Hoarding or saving things for no real reason				
9. Checking things over and over				
10. Putting objects in a certain order over and over				
11. Repeated "confessing" or asking others for assurance				
12. Repeated actions				
13. Making lists				
1. Bullies, threatens, or intimidates others				
2. Initiates physical fights				
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)				
4. Has been physically cruel to people				
5. Has been physically cruel to animals				
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)				
7. Has forced someone into sexual activity				
8. Has deliberately engaged in fire setting with the intention of causing serious damage				
9. Has deliberately destroyed others' property (other than by fire setting)				
10. Has broken into someone else's house, building, or car				
11. Lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)				
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)				
13. Stays out at night despite parental prohibitions, beginning before age 13 years				
14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)				
15. Is truant from school, beginning before age 13 years				
16. Been in **OTHER** legal trouble?				

Please check one box to the right of each of item.	Never	Some-times	Often	Very Often
17. Had concerns about sexual identity/sexual activity?				
18. Used/abused prescription/illegal drugs, alcohol or tobacco?				
19. Been pregnant?		**YES:**		

These questions are for parents of all ages!	
We would like to know a little about how you are doing.	
Are you getting enough sleep?	☐☐YES ☐☐NO
Do you have enough help caring for your child?	☐☐YES ☐☐NO
In the last 2 weeks, have you ever felt, down, depressed or hopeless?	☐☐YES ☐☐NO
In the last 2 weeks, have you felt little interest or pleasure in doing things?	☐☐YES ☐☐NO
Comments:	

HEALTH HISTORY

Are your child's immunizations up to date?_____Yes_____No

Please describe any overnight hospital stays or surgery that your child has had.

	Reason for Hospitalization	**Date**	**Name of Hospital**	**Length of Stay**
1.				
2.				
3.				
4.				

COMMENTS:

Please list any medications that your child takes now, including their dose.

Name of Medicine	Dose	Times when it is taken

Please list any medications that your child has taken in the past that have to do with the problem you are concerned about now.

Name of Medicine	Name of Medicine
1.	**4.**
2.	**5.**
3.	**6.**

Please list any alternative therapies, home remedies, or dietary supplements you are using or have used in the past.

Name of therapy, remedy or supplement	Name of therapy, remedy or supplement
1.	**4.**
2.	**5.**
3.	**6.**

Previous Medical Testing

Test	When	Where
EEG		
CT Scan		
MRI		
Other Tests:		

FAMILY HISTORY

Please list any relatives on either side of the family who have had the following:

Family History	Relationship to child	Mother's Side	Father's Side
ADHD/ Attention Deficit			
Anxiety/Panic			
Autism/Asperger's/PDD			
Bipolar Disorder			
Cancer			
Cerebral Palsy			
Child abuse or neglect			
Coordination problems			
Death in the First Year of Life			
Depression			
Drug or Alcohol Abuse			
Eating Disorder/Anorexia/Bulimia			
Genetic disorders			
Headaches			
Hearing Problems			
Heart Attack			
Heart Rhythm Problems			
Learning Disability			
Mental retardation			
Migraine headaches			
Mood Disorder			
Muscle disorders			
Neurodegenerative Disease			
Physical disabilities			
Schizophrenia			
Seizure or epilepsy			
Speech and language problems			
Spinal cord problems			
Stroke			
Sudden Death			
Thyroid disease			
Tics or movement disorder			
Trouble Walking			
Vision problems			
Other brain, spinal cord or nerve problems			

Parents' Information	Child's Father	Child's Mother
Age		
Occupation		
Highest education or school grade completed		
Learning problems (specify)		
Behavior problems (specify)		
Medical Problems (specify)		
Emotional problems (specify)		
Alcohol abuse		
Drug abuse		

Tobacco Exposure

Is anyone that lives in the home with your child a smoker? ☐ YES ☐ NO

Child's Brothers and Sisters:

Name	Age	Briefly list any medical, behavioral, or learning problems.

EDUCATIONAL AND SOCIAL HISTORY

Please list any early intervention, preschool, or school programs that your child has attended. **Check the N/A column if the area does not apply to your child.**

Education and Therapy Services	N/A	School/Program/Activity	Year(s)
Early intervention/ IFSP (ages 0-3)			
Occupational therapy			
Physical therapy			
Speech and language therapy			
Preschool			
Special Education Preschool			

These questions are for school age children only:			
Education and Therapy Services	**N/A**	**School/Program/Activity**	**Year(s)**
Child's current grade in school			
Testing for special services			
Special education/IEP/ 504 Plan			
Repeated a grade			
Most recent grades on report card			
Extracurricular activities			
Job (include number of hours)			
Vocational planning/BVR			
Time to be with friends or dating			

BEHAVIOR AND MOOD ASSESSMENT

Has Your Child or Adolescent:	Yes	No	Describe
These questions are for children of all ages:			
Been out of your care for an extended time?			
Experienced a traumatic event?			
Witnessed a traumatic event?			
Been sexually abused?			
Been physically abused?			
Been neglected (not fed, clothed, etc.)?			
Ever received mental health services (e.g., psychiatrist, counselor)?			

STRESS

Stress is mental or physical tension that occurs with demands of everyday life. Stress affects everyone and can be present in negative events (e.g., divorce), positive events (e.g., many extracurricular activities), or demands for high performance (such as striving for excellence in school or sports)? **Please list all <u>possible</u> sources of stress in the following areas of your family's life.**

Overall, how stressful is:	**Circle a number below:**
Home	***0 1 2 3 4 5 6 7 8 9 10*** *Not at all Stressful* *Extremely Stressful*
School	***0 1 2 3 4 5 6 7 8 9 10*** *Not at all Stressful* *Extremely Stressful*
Friends	***0 1 2 3 4 5 6 7 8 9 10*** *Not at all Stressful* *Extremely Stressful*
Work	***0 1 2 3 4 5 6 7 8 9 10*** *Not at all Stressful* *Extremely Stressful*
Other Stressor:	***0 1 2 3 4 5 6 7 8 9 10*** *Not at all Stressful* *Extremely Stressful*

HEALTH SYSTEMS REVIEW

Please let us know whether your child has any of the problems listed below. If YES, please give a brief description.

Area	NO	YES	BRIEF DESCRIPTION
General Health/Nutrition/ Immune system			
Poor appetite			
Unplanned weight gain/loss			
Eats non-foods			
Frequent fevers			
Trouble fighting off infections			
Lots of infections			
Eyes			
Vision problems			
Lazy eye/Strabismus			
Ears, Nose, Mouth, Throat			
Frequent ear infections			
Hearing problems			
Sinus problems			
Tooth decay or abscesses			
Heart			
Shortness of Breath or Dizziness with Exercise			
Activity limited due to a heart condition or chest pain			
Heart murmur or Rhythm problem			
Lungs			
Frequent Colds			
Chronic Cough			
Asthma			
Hay fever			
Stomach & Bowels			
Lots of vomiting			
Lots of diarrhea			
Lots of constipation			
Lots of stomachaches			
Blood in bowel movements			

Kidneys and Bladder	**NO**	**YES**	**BRIEF DESCRIPTION**
If over 5 years old, wetting the bed/pants			
Pain when urinating			
Urinating too often			
Bladder or kidney infections			
Unusual odor to urine			
Muscles and Bones			
Muscle pain			
Clumsy walk			
Poor posture			
Broken bones/joint problems			
Skin			
Unusual birth marks			
Lots of rashes			
Sores that won't heal			
Picking at skin or nails			
Brain and Nervous System			
Seizures with fever			
Seizures without fever			
Headaches			
Head Trauma			
Staring Spells			
Brain and Nervous System			
Weakness of arms or legs			
Movement or Voice Tics			
Banging head			
Hormones and Glands			
Blood sugar problems			
Thyroid problems			
Girls: Menstrual periods			Age Started: Last Period: Problems:
Blood and Cancer			
Low iron/ Iron deficiency			
Other anemia			
High lead levels			
Tumors or Cancer			

Is there anything else you feel is important we should know aboutyour child?

Thank you again for taking the time to complete this questionnaire. We look forward to meeting you and your child.

Accentra Behavioral and Educational Services, LLC
P.O. Box 4733
Chattanooga, TN 37405

Phone: 888-651-1597, Toll Free
423-304-2329, Alternate
423-425-9921, FAX

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Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for interventions, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about interventions, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your interventions and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Privacy Officer Contact Information:

Name:	Paul W. Baker
Phone:	1-888-651-1597, Toll Free
	423-304-2329, Alternate
	423-425-9921, FAX
Email:	drpaulbaker@accentrabehavioral.com

ACCENTRA
Behavioral & Educational Services

Client Acknowledgement of Receipt of HIPPA Notice Form

The **Health Insurance Portability and Accountability Act (HIPAA)**, a federal law provides new privacy protections and new patient's rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of interventions, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI interventions, payment, and health care operations. The Notice explains HIPAA and its applications to your personal health information in greater detail.

The law requires that we obtain your signature acknowledging that we have provided you with this information. Although this document is complex, it is very important that you read it carefully. We can discuss any questions
you have about the document or the procedures described by it at our next session.

When you sign below, it will represent an acknowledgement that you have received the HIPAA Notice form.

ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the HIPAA Notice of Privacy document. I further understand that I may seek further guidance on the contents of this document, and my rights, by meeting with Accentra Behavioral and Educational Services, LLC or its representatives.

Printed Name:_____ Date:_____

Signature:_____

P.O. Box 4733 •Chattanooga• TN 37405 •PH 423-304-2329 FAX 423-425-9921

ACCENTRA
Behavioral & Educational Services

CONSENT FOR BEHAVIOR CONSULTATION SERVICES

This document describes the nature of the agreement for professional services and the agreed upon limits of those services.

I, _____agree to have my child/dependent_____ to participate in behavior assessment and/or interventions services provided by **Accentra Behavioral and Educational Services, LLC.** I understand that the specific activities, goals, and desired outcomes of these services will be fully discussed with me and that I will have the opportunity to ask for clarification prior to signing this document. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation in services. If these services have been arranged or will be paid for by a third party (e.g., school, insurance plan, state agency), I also understand that my child/dependent is the primary client of the behavior consultant and that services will be designed primarily for client's benefit. Any other individuals or agencies (e.g., family, school professionals) that may be affected by the services are considered secondary clients.

If the services focus on increasing the client's skills, I understand that the first several sessions may consist of assessment activities designed to (a) evaluate his/her current skills (e.g., curricular assessments) and (b) determine which instructional strategies and interventions are likely to prove most effective (e.g., preference assessments, assessment of prompting strategies). The time allocated to these assessments will result in improved intervention. If the services are designed to improve ongoing problem behaviors, I understand that the beginning of those services will include functional assessment and/or functional analysis activities (e.g., interviews, checklists, direct observations) that are designed to provide information critical to the development of effective interventions procedures. I may be asked to assist in gathering some of this information by recording problem behavior as it occurs. This process may take a numbers of days or weeks prior to implementing intervention, but will increase the likelihood of effective intervention.

The subsequent services will be focused on development and implementation of instructional procedures and/or a behavior intervention plan. Prior to implementation, I may receive a printed copy of the results of any assessment and of any proposed instructional procedures or behavior intervention plans for my review and approval. The contents of those documents will be explained to me fully and any questions I have will be answered to my satisfaction. Subsequent implementation will involve training in the basics elements that are important for the intervention, details about the specific components of the intervention, and direct practice in the components for the family, educators, and/or other service providers. Full participation in these interventions and training activities is critical for a successful outcome. Ongoing collection of data will allow evaluation of the effectiveness of the intervention and will assist in developing any revisions that need to be made to ensure a good outcome. When the goal is achieved, we will discuss the discontinuation of services, as we will have achieved our therapeutic objectives. In addition, at regular progress reviews we may also discuss whether continuation of services would be beneficial, and any barriers to continuation.

Accentra Behavioral and Educational Services, LLC is committed to providing interventions that have been scientifically supported as most effective for problematic behavior. I am aware that other interventions that I am pursuing may affect my child's response to behavioral interventions. Thus, it is important to make the behavior consultant aware of those interventions and to partner with the behavior consultant to evaluate any associated therapeutic or detrimental effects of those interventions.

I understand that the procedures and outcomes of all assessment and interventions services are strictly confidential and will be released only to agencies or individuals specifically designated by me in writing. In addition, the fact that my child/dependent receives any services is protected and private information. I am aware that **Accentra Behavioral and Educational Services, LLC** may release information without my prior consent if so ordered by a court of law. I am also aware that providers are legally required to report suspected occurrences of child abuse or neglect or if I or my child present clear and present danger to ourselves or to others.

I understand that the client's assessment(s), data, recorded video segments of client's behavior and interventions services may be observed by supervisors or other employees as part of ongoing training and quality assurance activities. Information may be shared between these parties that It is understood that Paul W. Baker, Executive Director of Accentra Behavioral and Educational Services, LLC is seeking national certification as a behavior analyst and may receive receive ongoing supervision by a PhD- level Board Certified Behavior Analyst (BCBA-D). Further, it is understood that Coby Lund PhD, BCBA-D and/or another Board Certified Behavior Analyst (BCBA) associate of Integrated Behavioral Solutions, 53 Perimeter Center East, Suite 350, Atlanta, Georgia 30346-2204 serve(s) as supervisor to Paul W. Baker. Events occurring in those sessions will be discussed in closed supervision meetings of Paul W. Baker PhD and Coby Lund, PhD and/or BCBA associate(s). All individuals attending these meetings are bound by the same confidentiality guidelines as Accentra Behavioral and Educational Services, LLC in order to protect my privacy and that of my child/dependent. I am aware that a record of the interventions will be maintained and this record is available to me in written form upon request. I authorize and grant full consent for this information to be shared between supervisor and supervisee. I further understand that the identified supervisor may accompany Paul Baker to observations, meetings or other related events that involve the provision of behavioral services for the Client.

I understand that it may be necessary to share student records, data or audio- or videotape assessment and/or interventions sessions for supervision and consultative purposes. In the event that audio- or videotaping is necessary, I will be informed and asked to give written consent prior to taping.

I reserve the right to withdraw at any time from these services and I understand that such a withdrawal will not affect the client's right to services. In the event of withdrawal, I may request a list of other potential providers in the region. In addition, I reserve the right to refuse, at any time, the intervention that is being offered.

I am aware that the relationship between provider and client is a professional one that precludes ongoing social relationships, giving of gifts, or participation in personal events such as parties, graduations, etc.

These policies have been fully explained to me, and I fully and freely give my consent and permission for my dependent to receive behavior consultation and related services by Accentra Behavioral and Educational Services, LLC.

_____ _____
Parent or Guardian (legally authorized representative) Date

_____ _____
Parent or Guardian (legally authorized representative) Date

_____ _____
Provider Date

AUTHORIZATION TO RELEASE INFORMATION

Mail to: Accentra Behavioral and Educational Services, PO BOX 4733, Chattanooga, TN 37405 PH: 423-3042329 FAX: 423-425-9921

Client Name: _____ DOB_____

I understand this release is voluntary and applies to all programs and services operated under the auspices of Accentra Behavioral and Educational Services, LLC. I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition interventions, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. **I understand that I may revoke this authorization at any time by notifying Accentra Behavioral and Educational Services, LLC in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.**

I hereby authorize Accentra Behavioral and Educational Services, LLC to (check all that apply):
❒ Release to ❒ Obtain from

I hereby authorize Accentra Behavioral and Educational Services, LLC to exchange information:
❒ Verbally only ❒ In written form only ❒ Both verbally and in writing

Organization or Individual receiving/communicating the information:

Name of Organization/Individual

Address **City, State** **Zip** **Phone**

Description of information to be exchanged / released / obtained:

❒ Education records ❒ Medical records

❒ Evaluation/assessment/eligibility records ❒ **Other** _____

❒ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

Duration of release (check one):

❒ This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.

❒ From _____(MM/DD/YYYY) To _____ (MM/DD/YYYY)

The purpose if this release is: Behavioral Consultation and Assessment

_____

Signature of Student/Consumer/Patient or Legally Authorized Representative **Date**

_____

PRINT NAME and Relationship of Legally Authorized Representative to Student/Consumer **Date**