



Dear Parent(s),

Thank you for your interest in our program. We appreciate you selecting Sunderlin Behavioral Intervention as your child's Applied Behavior Analysis (ABA) provider. We will assist you with verifying your insurance benefits for autism coverage. If ABA is a covered benefit under your insurance plan, we will obtain an authorization from your insurance to start services. In order to begin the process, we need the documents outlined below.

Attached you will find the following documents:

- Private Insurance Information Form
- Confidentiality Policy and Client Release of Information
- Release of Media Form
- Notice of Privacy Practices
- Consent and Agreement for Behavioral Assessment
- Financial Policy Patient Responsibility
- Child Availability Form
- Credit Card Form
- ABA History Questionnaire

In addition, the following documents are **REQUIRED** to verify ABA benefits and to submit a request for authorization to your insurance company:

- A copy of the front AND back of your child's insurance card. Please include secondary insurance card, if any.
- A prescription or letter from a medical doctor or a licensed professional stating that your child has a diagnosis of Autism Spectrum Disorder (ASD).
- A copy of the diagnostic report that shows the DSM-5 diagnostic code of F84.0

Please complete, sign and return **all** documents to our office as soon as possible. This information may be faxed, mailed, or emailed to us:

7140 SW Fir Loop Suite 105  
Portland OR, 97223  
Fax: (805) 823-4462

[Intake.sunderlinbcba@gmail.com](mailto:intake.sunderlinbcba@gmail.com)

Upon receipt of these documents, our office will verify your insurance plan and notify you of your autism benefits. If you have any questions, please contact our Office Manager at (971) 249-3791

Sincerely,

Yrenka Lolli-Sunderlin MS, BCBA  
Executive Director

Enclosures

7140 SW Fir Loop #105, Portland, OR 97223  
Phone: (971) 249-3791 Fax: (805) 823-4462  
Email: [intake.sunderlinbcba@gmail.com](mailto:intake.sunderlinbcba@gmail.com)  
[www.sunderlinbcba.com](http://www.sunderlinbcba.com)



**CONFIDENTIALITY POLICY AND CLIENT RELEASE OF INFORMATION**

At Sunderlin Behavioral Intervention all client’s records (verbal or written) will not to be released or shared with outside parties unless a consent form has been signed. In such case, the information may only be shared with the specific parties authorized on the consent form.

I hereby give my permission for all information concerning the evaluation and treatment of my child to be released and transmitted between Sunderlin Behavioral Interventions and the following professionals or agencies:

Agency: \_\_\_\_\_

Child’s Pediatrician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Other: \_\_\_\_\_

Child’s School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Other: \_\_\_\_\_

I understand that this release form is valid for the period of time in which the above-named client is in active treatment with Sunderlin Behavioral Interventions. All or any of this release is cancelled upon written notification from the undersigned. A photocopy of the consent for release of information is as valid as the original.

I give permission for my child to be videotaped, for the purpose of clinical documentation. Such tapes may only be shared with Sunderlin Behavioral Interventions staff and the above named professionals or agencies for which there is a release of information. I further understand that according to the Family Rights Act, my permission to video tape shall not exceed 6 months duration from the time the consent is signed.

Initial: \_\_\_\_\_ Yes No Date \_\_\_\_\_

I give permission for my child to be videotaped, for the purposes of training and education. Such tapes may be used Sunderlin Behavioral Interventions staff trainings and community trainings provided by Sunderlin Behavioral. I further understand that according to the Family Rights Act, my permission to video tape shall not exceed 6 months duration from the time consent is signed.

Initial: \_\_\_\_\_ Yes No Date \_\_\_\_\_



I give permission for my child to be in the therapy room. I understand that other parents may be present and watching their own children at the same time.

Initial: \_\_\_\_\_ Yes No Date \_\_\_\_\_

I give permission for my child to participate in a group setting which may be observed by other parents observing their child at the same time.

Initial: \_\_\_\_\_ Yes No Date \_\_\_\_\_

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The caregiver/parent(s) acknowledges that they have been informed and understand our confidentiality policy.

Print Client's Full Name: \_\_\_\_\_

Print Legal Guardian's Full Name: \_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



**MEDIA RELEASE FORM**

You have been asked to provide consent for Sunderlin Behavioral Interventions to photograph and/or videotape your child, \_\_\_\_\_, engaged in a therapy session with our staff. With your permission, we may utilize the photograph and/or video recordings on our company website and/or social media site (Facebook, twitter, etc....) for showing what a typical therapy session looks like at our clinic. Any photograph and/or video recordings that may be used on our company website and/or social media site will only show your child in a positive and respectful manner (e.g., fully engaged with the therapist and enjoying the session). You and your child’s individual privacy will be maintained, and you have the right to view and approve any photograph and/or videos prior to the inclusion of a photograph and/or video on our company website and/or social media site upon your request.

Sunderlin Behavioral Interventions would also like to ask for your permission to use photograph and/or video record for research and/or presentation for the sole purpose of educating others on therapy within our company. Please indicate which uses you consent to by initialing below. You are free to initial any number of spaces, from zero to all the spaces, and your response will in no way affect you or your child’s current or future treatment. You also have the right to revoke your permission for us to use photographs and/or videos of your child at any time by writing a letter stating so. Sunderlin Behavioral Interventions will honor your request without any negative affect on your child’s current or future treatment. Photographs and/or video recordings will remain securely stored in a secure data system on company premises. If you would like a copy of your child’s video, this can be provided upon your request.

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I give permission for portions of photographs and/or videotaped treatment sessions to be shown on Sunderlin Behavioral Interventions website and or social media site.

Initials: \_\_\_\_\_

I give permission for portions of photograph and/or videotaped treatment sessions to be shown during educational and/or research presentations.

Initials: \_\_\_\_\_

I give permission for portions of photograph and/or videotaped treatment sessions to be shown for clinical or medical record review through HIPAA compliant software.

Initials: \_\_\_\_\_

I have read the above description and give my consent for the use of photographs and/or videotapes as indicated above.

\_\_\_\_\_  
Print Your Child’s Full Name

\_\_\_\_\_  
Signature parent/guardian

\_\_\_\_\_  
Date



## 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 Corporate Office: Phone (805) 230-3701  
Address 30343 Canwood St Suite 100, Agoura CA, 91301.

### **Who Will Follow This Notice**

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

### **Your Health Information**

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

### **How We May Use and Disclose Health Information About You**

#### **For Treatment**

We may use health information about you to provide you services. We may disclose information about you to treatment staff, office staff or other personnel who are involved in taking care of you and your services

For example, your occupational therapist may be treating your child for a developmental condition and may need to know you child has other developmental challenges pertaining speech. The therapist may discuss your child's case with the speech therapist to determine the most appropriate care for your child.

Personnel in our office may not share information with people who do not work in our office without written authorization from you.

#### **For Payment**

We may use and disclose health information about you so that the services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

#### **For Service Operations**

We may use and disclose health information about you in order to run the office and make sure that you and our clients receive quality care. For example, we may use your information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our clients to help us decide what additional services we should offer, how we can become more efficient, or



whether certain new treatments are effective. We may also tell you about or recommend possible treatment options or alternatives that may be of interest to you.

### **Scheduling and Other Routine Office Operations**

We may use your information to contact you regarding scheduling. We may use your information to contact you for other routine office operations such as completing required paperwork.

### **Special Situations**

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

### **To Avert a Serious Threat to Health or Safety**

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

### **Required by Law**

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

### **Research**

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

### **Public Health Risks**

We may disclose health information about you for public health reasons to prevent or control disease, injury or disability, suspected abuse or neglect, and/or non-accidental physical injuries.

### **Health Oversight Activities**

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

### **Lawsuits and Disputes**

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

### **Law Enforcement**

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

### **Information Not Personally Identifiable**

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.



### **Family and Friends**

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your relative when you bring your relative with you into the treatment room during treatment or while treatment is discussed.

### **Other Uses and Disclosures of Health Information**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

### **Your Rights Regarding Health Information About You**

You have the following rights regarding health information we maintain about you:

#### **Right to Inspect and Copy**

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to a Clinical Director in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

#### **Right to Amend**

If you believe health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- A. We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- B. Is not part of the health information that we keep.
- C. You would not be permitted to inspect and copy.
- D. Is accurate and complete.



**Right to Request Restrictions**

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about additional treatments not being provided by this office.

**We are Not Required to Agree to Your Request**

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit a Request for Restricting Uses and Disclosures and Confidential Communications Form Information to a Clinical Director.

**Right to Request Confidential Communications**

You have the right to request that we communicate with you about service matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, please do so in writing to a Clinical Director. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice**

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact a Clinical Director.

**Changes to This Notice**

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. Please submit your complaint to 30343 Canwood St. Suite 100, Agoura Hills, CA 91301. You will not be penalized for filing a complaint.

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**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received the Notice of Privacy Practices statement of Sunderlin Behavioral Interventions.

Client’s Name: \_\_\_\_\_ Legal Guardian’s Name: \_\_\_\_\_

Legal Guardian’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## Consent and Agreement for Behavioral Assessment

I, \_\_\_\_\_, agree to allow the individual named below to participate in the following services:

- Behavioral Assessment
- Report Writing

This agreement concerns:

Client's Full Name: \_\_\_\_\_ DOB of Client: \_\_\_\_\_

I understand that these services may include direct, face-to-face contact, interviewing, behavioral, social, and communication skills assessment. They may also include time required by a BCBA (Board Certified Behavior Analyst) for the reading of records, consultations with other Clinicians and Professionals, compiling and evaluation assessment results, and any other activities to support these services.

I understand this evaluation is to be done for the purpose(s) of:

1. Making recommendations for behavioral, educational, social, and communication skills treatment planning

I also understand Sunderlin Behavioral Interventions agrees to the following:

1. The procedures for selecting and conducting assessments, interpreting and storing the results, and maintaining my privacy will be carried out in accord with the widely accepted rules and guidelines or organizations (e.g., HIPAA, FERPA, etc.)
2. Assessment methods will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and populations have been established.) All assessments are chosen and conducted, and the results are evaluated based on findings and guidelines from the scientific and professional literature.
3. Reports and assessment results will be kept in a safe place. We agree to help as much as we can, by supplying full answers, making an honest effort, and working as best we can to make sure the findings are accurate.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date



## FINANCIAL POLICY & PATIENT RESPONSIBILITY

### It is the Patient’s Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co- payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physicians (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment and or deductible at the time of the service.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.
- Outstanding payments past 30 days will accrue a \$35 late fee
- To notify our office immediately when your insurance plan or carrier has changed.

### It is Sunderlin Behavioral Interventions responsibility:

- To provide quality therapy services
- To verify benefits and eligibility as a courtesy to the patient (please refer to the first bullet point)
- To file insurance claims as a courtesy to the patient. A 60-day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.

### Cancellation Policy:

Appointments cancelled with less than **18-hour notice** are charged a **\$25 cancellation fee**

### No Show Policy:

If an appointment was scheduled **AND** not cancelled, a **“no show” fee of \$50.00 will be assessed.**

### Credit Card Policy:

A credit card form **must** be provided **before** the first initial session date. Credit card payments are processed on a weekly basis for services rendered the prior week.

### Financial Policy Acknowledgement:

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage. I am ultimately responsible for the balance on my account for any services rendered.

Legal Guardian’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Release of Medical Information and Assignment of Benefits:

I authorize the release of medical information necessary for filing health insurance claims for me by Sunderlin Behavioral Interventions. I also authorize my insurance carrier(s) to make payment directly to Sunderlin Behavioral Intervention.

Legal Guardian’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**We normally operate service between the hours of 8am and 8:30pm Monday-Friday and variable hours on Saturday and Sunday. Please indicate the full days and times your child is available for services in the chart below. The more availability you provide, the better we will be able to plan for your child and schedule services.**

Client's Full Name: \_\_\_\_\_

Legal Guardian's Full Name: \_\_\_\_\_

Days	Availability for Session at Home
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

**If interested in services at school, please write in the times your child has school each day in the chart below:**

Days	Availability for Session at School
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	



## Intake Form for Clients

### Client Information

First Name	Last Name	Middle Initial	
Address	City	State	Zip Code
Date of Birth	Diagnosis	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

### Legal Guardian Information

First Name	Last Name	Date of Birth	
Address	City	State	Zip Code
Relationship to Client	Phone Number	Secondary Phone Number	
Email Address			
Employer	Social Security Number		

### Insurance Information

Primary Insurance Provider	Policy Number	Group Number
Secondary Insurance Provider	Policy Number	Group Number
Primary Insurance Phone Number	Secondary Insurance Phone Number	



**Service Information**

**Check all services you are interested in receiving:**

- Applied Behavior Analysis     Parent Training     Social SkillsLife Coaching

**If interested in school services:**

School Name

School District

Address

City

State

Zip Code

Teacher/Director's Name

Phone Number

**Behavioral Concerns**

**Please list any current behavioral concerns for the client:**

**Pediatric Information**

Pediatrician's Name

Phone Number

Fax Number

**Referral Information**

**How did you hear about us? Check all that apply:**

- ALP Website     Facebook     Community Event     Current or Former Client

| Pediatrician (please provide name): \_\_\_\_\_

| Psychologist (please provide name): \_\_\_\_\_

| Speech Therapist (please provide name): \_\_\_\_\_

| Other (please provide name): \_\_\_\_\_



**Medical History**

Are immunizations up to date: Yes No

**Medication Allergies**

Please list any known allergies to medications:

**Patient History Questionnaire**

Please check all that apply:

<input type="checkbox"/> Ear infections	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Muscle disorders
<input type="checkbox"/> Headaches	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Endocrine disorders	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Vision problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Respiratory problems	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Constipation	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures

**List of Current Medications:**

Medication:	Dose:	Reason:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

**Family History**

Please check any of the following conditions that are or have been present in the child's immediate or extended biological family:

	Mother	Father	Siblings	Mother's Relatives	Father's Relatives
<b>Developmental Delay</b>					
<b>ADHD</b>					
<b>Mental Retardation</b>					

	Mother	Father	Siblings	Mother's Relatives	Father's Relatives
Learning Disability					
Special Education					
Cerebral Palsy					
Blindness					
Deafness					
Seizures					
Autism					
Tics/Tourette's					
Enuresis (bedwetting)					
Depression					
Anxiety					
Suicide					
OCD					
Schizophrenia					
Sleep disorder					
Alcoholism					
Drug abuse					
Other:					

**Applied Behavioral Applied Questionnaire**

Has your child received prior ABA services? Yes No

If yes, please provide name of provider and how long your child was receiving ABA:



Has your child ever been diagnosed with Autism, PDD-NOS, Asperger's, Retts, or CDD?

If yes, please provide licensed provider information:

Provider name: \_\_\_\_\_

Provider address: \_\_\_\_\_

Provider phone number: \_\_\_\_\_

Provider NPI: \_\_\_\_\_

Are there any family or legal issues (e.g., divorce, child custody, etc.)?

If yes, please briefly describe:

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Are there any spiritual/cultural beliefs that would interfere with receiving ABA treatment?

If yes, please briefly describe:

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#### Notes



## **The Work Environment**

Sunderlin Behavioral Interventions is under legal obligation to provide a safe and harassment free working environment for all of our staff. This includes the environments where we provide services to your family member such as your home. Please ensure that your home is free of any hazards prior to our session and that you interact with all staff members in a professional manner.

Please indicate your awareness of the following expectations by initialing each item.

### **General**

- \_\_\_\_\_ Fully functioning smoke alarms
- \_\_\_\_\_ Fully functioning carbon dioxide alarms
- \_\_\_\_\_ Working plumbing
- \_\_\_\_\_ Working internet service
- \_\_\_\_\_ All chemicals cleaning products need to be properly stored
- \_\_\_\_\_ All sharp objects need to be properly secured and stored

### **Other Household Members**

- \_\_\_\_\_ All household members maintain themselves in a presentable manner during work times (i.e. sober and dressed)
- \_\_\_\_\_ Conflicts between family members that may occur during work times and are handled respectfully
- \_\_\_\_\_ No illegal activities on premises
- \_\_\_\_\_ Siblings are welcome to participate unless recommended not to by the clinical team
- \_\_\_\_\_ Employee is not responsible for any damage caused by client in the work area

### **Bathrooms**

- \_\_\_\_\_ Regularly cleaned
- \_\_\_\_\_ Free of soiled diapers and soiled clothing
- \_\_\_\_\_ Stocked with supplies (i.e. soap, towels, toilet paper)

### **Work Area**

- \_\_\_\_\_ Floor space available
- \_\_\_\_\_ Regularly vacuumed/ swept
- \_\_\_\_\_ Free of debris
- \_\_\_\_\_ Tables and chairs available
- \_\_\_\_\_ Any work materials are stored securely



Please indicate the following as Yes or No or N/A

**Firearms**

- \_\_\_\_\_ Firearms present in the home
- \_\_\_\_\_ Firearms locked and properly stored

**Animals**

- \_\_\_\_\_ Animals are in the home
- \_\_\_\_\_ Animals are up to date on all recommended vaccines
- \_\_\_\_\_ Animals have ever been aggressive

The above conditions are deemed necessary to provide a safe and effective work environment. If conditions are not consistently met, the staff has the right to immediately vacate the premises. A team meeting will then be called to discuss the conditions.

I \_\_\_\_\_, parent/guardian of \_\_\_\_\_ understand the need to adhere to the above conditions and understand that failure to do so may result in the immediate cancellation of services.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



**Parent/Guardian Participation Policy**

Please initial below on each line after reading the summarization of important policies regarding our service delivery agreement.

<b>Initial</b>	
	You or your authorized representative (e.g., grandparent, other relative, and daycare provider) must be present and participate during the session to maximize the impact of the intervention. (Must be 18 years and older)
	You are encouraged to ask questions, actively participate in your family member’s session and incorporate the activities and techniques you learn into your family’s daily routine.
	Since regular sessions are required for your family member to make progress, you are asked minimize cancellation of your family member’s sessions.
	Please notify the Behavioral Therapist/Case Supervisor 18 hours in advance if you must cancel a session. Three (3) “no shows” without prior notice will result in notification to your Insurance Funding Source and possible Discharge of Service from Sunderlin.
	Observation and Treatment overlaps (ABA services) are an essential part of Supervision and Teaching. Each family is expected to allow observations and shadow appointments in their home.
	At least one Caregiver is expected to participate regularly scheduled Supervision meetings where progress toward goals will be reviewed.
	Parent must stay within close proximity while session is in progress to supervise and intervene when necessary. Should a parent leave the room for any reason the session will be suspended until the parent returns.

I have read and acknowledge the Participation Policy.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



## **Discharge of Services**

Individuals can be discharged from services for failure to comply with policies of Sunderlin Behavioral Intervention. The following will result in discharge of ABA services.

- Data demonstrates that services have been effective, and the acquisition program and objectives have been reached significant enough to decrease the existing developmental gap;
- Data demonstrates that the services have not been effective, as determined data collection;
- There have been repeated missed appointments and/or lack of caregiver supervision;
- Parent/primary caregiver(s) chooses to stop services or desires another type of intervention.
- Failure to comply with more than 80% of the recommended ABA plan of treatment by the BCBA provider.
- Failure to adhere to the home expectations checklist located in the Work environment section of the service delivery agreement
- If you should have an outstanding balance more than 30 days.
- 30-day notice will be given to families with Private insurance policies
- 60-day notice will be given to families with State funded insurance polices

By signing below, I am acknowledging that I have read and understand the terms and conditions.

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Signature of Parent/Guardian

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Date



## Sunderlin Behavioral Interventions Grievance Policy

Name of Family Member \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sunderlin encourages parents to try to resolve their concerns about our services informally, we also recognize that some concerns will not be resolved in that manner and may require formal investigation and resolution.

Please first speak to your Case Supervisor openly about your concerns. Please do not discuss your concerns with your Behavioral Therapist. The formal Grievance Procedure described below should be used to address concerns about your family member services that are not resolved formally. Allegations of abuse, neglect, exploitation or misappropriation of funds should not be addressed through the grievance process. Rather, such issues should be reported directly and immediately to the Clinical Director.

At any time during this process, you may contact your health plan or any other advocacy organization for assistance. A list of team members with the contact information will be provided to you at the beginning of treatment.

1. Any service-related problem which you wish to have considered as a grievance should be described in writing and submitted to your Case Supervisor. The Case Supervisor will respond to you in writing within five (5) business days. Your Case Supervisor is obligated to assist you with the writing and submission of a grievance if you need assistance. If your concerns are related to a violation of rights of privacy, please contact the Case Supervisor immediately. All personal rights issues will be investigated immediately.
2. If the Case Supervisor does not resolve the grievances to your satisfaction, you may submit a written statement of the grievance to the Founder/Clinical Director within fifteen (15) business days following receipt of the Case Supervisor's written response. The determination of the Founder/Clinical Director shall be the final.
3. At any time during the process, you may submit a grievance to your health plan.
4. No form of retaliation shall occur nor shall any barrier to service be created because of the grievance.
5. All documentation regarding the grievance will be filed in the case record.
6. When any program related concerns are informally resolved, Sunderlin will include summary information about the resolution on the outcome measures reports.
7. The grievance process does not apply to denial or limitations of service issued by your health plan. Denials or limitations of services issued by the health plan must be appealed directly to the health plan.

Any and all controversies, claims, or disputes (collectively "Disputes") arising out of or related to your relationship with Sunderlin or the services we provide for you or your child, which cannot be resolved pursuant to the Grievance Procedure, including the interpretation of the documents contained in the Intake Packet and the scope or applicability of this agreement for dispute resolution, will be resolved according to the following procedures.

1. **Binding Arbitration:** You agree to proceed to final and binding arbitration ("Arbitration"), before a single neutral arbitrator, conducted in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, except as modified herein. You or we may initiate Arbitration via a written notice ("Arbitration Notice"), which



must be delivered no later than thirty (30) days following the conclusion of Mediation. The Arbitration will take place in Portland, Oregon. We will have thirty (30) days from the date of the Arbitration Notice to jointly agree on an arbitrator to conduct the Arbitration. The arbitrator will follow Oregon law in adjudicating the dispute. In the event we cannot agree on an arbitrator, we shall each select an arbitrator, affiliated with JAMS, who will jointly select a third arbitrator who will ultimately adjudicate the Dispute. The arbitrator will provide a detailed written statement of decision, which will be part of the Arbitration award and admissible in any judicial proceeding to confirm, correct or vacate the award. The prevailing party will be entitled to all fees and costs associated with Arbitration (or enforcement of an award therefrom), including, but not limited to, reasonable attorney's fees, from the other party upon completion of the Arbitration.

2. Class Action Waiver: You hereby agree that the Arbitration of any Dispute will take place on an individual basis and will not include any form of class or representative action ("Class Action") and you hereby agree to waive any Class Actions related to a Dispute ("Class Action Waiver"). You hereby acknowledge and agree that any claim you submit to Arbitration will be on your own behalf and you will not seek to represent the interest of another person or entity. If this Class Action Waiver is held to be unenforceable under applicable law, then it will be excluded from this Dispute Resolution Agreement, the balance of this Dispute Resolution Agreement and any other documents contained in this Intake Packet will be interpreted as if this Class Action Waiver were so excluded, and the balance of this Dispute Resolution Agreement and any other documents contained in the Intake Packet will be enforceable according to their terms.

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Signature of Parent/Guardian/Conservator

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Date