CROTCHED MOUNTAIN

Dear Parent:

Thank you for your interest in obtaining services through Crotched Mountain's Ready Set Connect program. We're excited for you to join us! Enclosed is a questionnaire and record releases. If possible, please include a copy of your insurance card(s) when returning the forms.

It is extremely important that each one of these forms be filled out as completely as possible and mailed back to us before your appointment date; this includes personal and insurance information, as well as any required signatures.

If you have any questions or concerns, please call us at **603-224-7630**. Again, thank you for your interest. We look forward to receiving your intake information and meeting here with you at the clinic.

Ready Set Connect (Concord)
57 Regional Drive, Ste. 7
Concord, NH 03301

Ready Set Connect (Manchester)
340 Granite St., Second Floor
Manchester, NH 03102

Ready Set Connect (Greenfield)
1 Verney Drive
Greenfield, NH 03047

Tel: (603) 224-7630 *Fax:* (603) 662-8183 *Web:* readysetconnect.org

Checklist for Visits

Please complete the following steps prior to your child's visit

Intake form

- *Contact and insurance information. Please fill out completely, sign and date.*

Releases

- *Complete "Authorization to Exchange Information" sign and date.*
- *Photo Release: sign and date*
- *Privacy Notice: sign and date*

Referral and other documentation

- *Insurance companies require a letter from your child's physician stating he/she has an autism diagnosis and ABA is medically necessary*
- *Please bring a copy of the comprehensive evaluation from from the time of diagnosis*

Insurance authorization

- *Is the service requested covered by your plan? Call your insurance carrier to find out. There may be co-pays or coinsurance you are responsible for.*

Insurance cards

- *Please bring all current insurance cards with you to the clinic.*

Ready Set Connect

Intake Form: Contact and Insurance Information

Personal contact information			***Guardian/Parent contact (1) (If applicable)***
Client's name			***Guardian/parent's name***
Date of birth (Month/Day/Year)	***M***	***F***	***Relationship to client***
Street address			***Street address [if different from client's address]***
Street address 2			***Street address 2***
City/state/zip			***City/State/Zip***
Day telephone			***Day phone number***
Evening telephone			***Evening phone number***
Email address			***Email address***

Guardian/Parent contact (2) (If applicable)		
Second guardian name		***Relationship to client***
Street address [if different from above]		***Day phone number***
Street address 2		***E-mail***
City/state/zip		***Evening phone number***
Emergency contact information		
Emergency contact		***Relationship to client***
Day phone number	***Evening phone number***	***Cell phone number***

Referring sources ***Insurance authorization and billing procedures oblige us to send a copy of clinic reports to the primary care physician, or to the physician who referred you or your child for services. We endorse this practice, which facilitates continuity of care. Please indicate which physician should receive a copy of clinic reports.***					
Primary care physician name			***Other referring physician name***		
Street address			***Street address***		
City/state/zip			***City/state/zip***		
Phone number			***Phone number***		
Is this the physician who should receive a copy of the clinic reports?	***yes***	***no***	***Is this the physician who should receive a copy of the clinic reports?***	***yes***	***no***
Referring Diagnosis:					

Insurance company information					
Primary insurance company name			***Secondary insurance company name***		
Insurance company address			***Insurance company address***		
Insurance company phone number			***Insurance company phone number***		
Policy Holder's name			***Guarantor name (Person responsible for payment)***		
Policy Holder's birth date			***Guarantor birth date***		
Policy Holder's social security number			***Guarantor social security number***		
Policy Holder's employer's name			***Guarantor employer's name***		
Identification number:			*Identification number:*		
Prefix:	***Certificate number:***	***Suffix***	***Prefix***	***Certificate number***	***Suffix***
Group number			***Group number***		

Telephone message policy

We will leave messages at the telephone numbers listed unless otherwise indicated. All messages respect your confidentiality.

Payment information and policy

You have the option of paying for the clinic visit privately, or procuring payment through your insurance carrier (when applicable). Not all of the services offered by our clinic are covered by all insurance plans. It is your responsibility to assure that your plan covers the service that you have requested. We will be contacting your insurance carrier to verify your coverage.

Signature section.

Your signature is required for the reasons explained in the three paragraphs that follow. Please read these paragraphs, and sign on the line at the bottom if you agree to these conditions. Please do not hesitate to contact us with any questions or concerns you may have about this section.

1. ***Authorization of release of information***
   I authorize the Crotched Mountain ABA services to send a copy of any report to the primary care physician, and/or to the referring physician, as indicated on the reverse side of this page.
2. ***Authorization to be treated for assessment and treatment***
   I agree to be evaluated and treated, or to have my child/dependent for assessment and treatment, by an ABA Therapist. I understand that I can revoke this agreement at any time.
3. ***Assuring payment through your insurance plan***
   I hereby assign all medical benefits to which I am entitled and authorize and direct my insurance carrier(s) to issue payment of medical benefits directly to Crotched Mountain Rehabilitation Center for medical services rendered to my dependents or me. I hereby authorize the release of any medical information necessary to process insurance claims for medical services rendered to me or my dependents. I understand that I am responsible for all copays, coinsurances, non-covered services, cancellations, and appointments that are not honored by my insurance company or any other party.
4. ***In the event of an emergency*** *requiring hospital treatment, every effort will be made to contact parents (person* otherwise designated) before any action is taken. Please note that children will be taken to the closest hospital in the event of an emergency.

   Cancellation and No-Show Policy: Appointments must be cancelled a minimum of 24 hours in advance. I understand if I fail to cancel an appointment without sufficient notice or if I fail to show up for a scheduled appointment, I will be charged $50.00.

Signed:_____ ***Date:***_____

Ready Set Connect

Intake Form: General Medical Information for Children

The main concerns that I have about my child are:
1.
2.
3.

Concerns that other people (doctors, teachers, family members) have about my child are:
1.
2.
3.

PAST MEDICAL, DEVELOPMENTAL, OR MENTAL HEALTH DIAGNOSES:
List any diagnoses your child may already have, or diagnoses you think your child might have

Diagnosis	***When was diagnosis made?***	***Who made the diagnosis?***	***Do you agree with this diagnosis? (Circle one)***	***Comments***
			Y N Maybe	
			Y N Maybe	
			Y N Maybe	
			Y N Maybe	

MEDICATIONS
List any medications taken by your child. Include dose and frequency if possible:

1.
2.
3.
4.

ALLERGIES
List any allergies your child may have

1.
2.
3.

Ready Set Connect

Intake Form: Family History

Is this child adopted?……	***Y N***	*If yes, at what age?*
Is this a foster child?……	***Y N***	*If yes, for how long?*

Does anyone in the child's family have any of the following conditions? ***This section refers to biological family members (blood relatives)***	
Diagnosis	***Which family member has this diagnosis?***
Learning disability	
Attention deficit disorder	
Autism or PDD	
Mental retardation	
Cerebral palsy	
Birth defect	
Epilepsy	
Chromosomal abnormality	
Vision impairment	
Other developmental disability	
Depression	
Psychosis	
Bipolar disorder	
Anxiety	
Any Chronic Infectious disease	

CHILD CARE		
Type of child care	***Number of hours per week***	***Number of other children at child care site***

Ready Set Connect

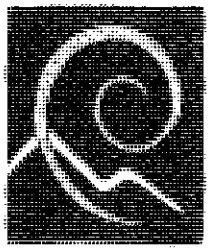
Intake form: Educational and Therapeutic Services: Children

Early Intervention services	*# hours/ week*	*Comments*
Home visitor		
Center-based individual visit		
Child play group		
Parent support/information group		
Other (please describe)		

Therapeutic Services:	*# Hours/ week*	*Site of therapy*	*Comments*
Individual speech therapy			
Group speech therapy			
Occupational therapy			
Physical therapy			
Counseling or psychotherapy			
Social skills group			
Other therapies (please describe)			

School program	*#hours/week*	*Any comments or concerns?*
Regular education setting		
Resource room		
Special education setting		

School contact information
School name
School street address
City/State/zip
Phone number
Teacher's name
Name of other contact person who knows your child



OFFERING A LIFELONG ALLIANCE TO PEOPLE
CROTCHED MOUNTAIN WITH DISABILITIES

Authorization to Exchange Information

Patient's Name:_____**Date Of Birth**_____

I request and authorize Ready, Set, Connect! to exchange information with the personnel of _____
_____
_____

Signed_____**Date**_____

Crotched Mountain Foundation
One Verney Drive, Greenfield, NH 03047 *tel* 603.547.3311 *fax* 603.547.3232
web www.crotchedmountain.org

OFFERING A LIFELONG ALLIANCE TO PEOPLE WITH DISABILITIES

CROTCHED MOUNTAIN

HIPAA Authorization to Use/Disclose Protected Health Information for Marketing and Public Relations

Permission for Individual (please print name): _____
Name of Parent(s)/Legal Representative(s)(if applicable):_____
Address: _____
Phone: (home) _____ (work) _____ (email) _____

Individuals who receive treatment through Crotched Mountain Foundation or other Crotched Mountain Foundation affiliated corporations (CM), as well as individuals who participate in CM activities may be the subject of photographs, audio and/or video recordings taken for possible inclusion in promotional, educational, fundraising, marketing and/or publicity efforts on behalf of CM. Examples of this may include, but not be limited to, printed or electronic articles, flyers, brochures, newsletters, newspaper stories, presentations, public events, conferences, web sites and social media. The Individual and their Representative (if applicable) understanding that CM will be sensitive to the dignity of the Individual in the use of their name, photographs, video, voice and/or biographical protected health information.

As the Individual or their Representative executing this authorization, I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Marketing Department at the address below, however, that will not affect any prior action that has been taken in reliance of this authorization.
- I may refuse to grant permission for use of photographs, video, voice and/or biographical/progress information.
- If I refuse to sign this permission my treatment, services or ability to participate in CM activities will not be affected.
- Information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and CM has no control over any such re-disclosure.
- All original material remains the property of CM.
- I understand that I will not be paid for the use of this material and waive any claim to copyright or royalties.
- As required by the Health Insurance Portability and Accountability Act of 1996, CM may not use or disclose my protected health information except as provided in CM's Notice of Privacy Practices, which may be found at www.cmf.org/privacy, without my authorization. My or my Representative's signature on this form indicates that I am giving permission for the uses and disclosures of protected health information described herein.
- This authorization will terminate six (6) years from the effective date identified below.

I have read the above and grant permission to CM on my own behalf and on behalf of my agents, representatives, heirs, administrators and assigns, to disclose my name, photographs, video, voice and/or biographical protected health information in accordance with this authorization.

Signature: _____ **Printed Name:** _____
(if signer is not the Individual, print the signer's relationship, e.g. parent or other title of representative and print signer's name)

Effective Date: _____

Ready Set Connect
57 Regional Drive, Suite 7 Concord, NH 03301
(603) 226-2900

Privacy Notice - Effective April 14, 2003

This Document Is Available in an Alternative Format Upon Request

THIS *NOTICE* DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS *NOTICE* CAREFULLY.

Please read and return to Ready Set Connect - a signed copy of page 3. Your signature is required before services can be initiated.

Ready Set Connect respects your right to privacy, especially related to your personal health information. To ensure your privacy, all employees, contracted providers, volunteers, and companies performing business functions for Ready Set Connect will treat personal and identifiable health information with the utmost confidentiality.
Ready Set Connect is required by law to maintain the privacy of your health information, to follow the terms of this *Notice*, and to inform you of our legal duties and privacy practices with respect to your health information.

How Ready Set Connect May Use or Disclose Your Health Information

1. Ready Set Connect will need to utilize and release personal health information for treatment, payment and healthcare operations. **A) Treatment** - We will use your health information to provide the evaluation and consultation services you have requested. We may disclose your health information to Ready Set Connect therapists and other persons involved in providing or coordinating your services. **B) Payment** - We may use and disclose your health information so that your assistive technology services may be billed to, and payment may be collected from, you, an insurance company or a third party. **C) Healthcare Operations** - We may use and/or disclose health information in connection with our own quality assessment activities and for training and supervision of staff members.

2. We will share your protected health information with third party "business associates" performing various activities that are essential to the operations of our organization. The release of confidential information to business associates will occur only when necessary to provide the services you requested or to process essential functions such as billing, accounting, quality assurance, or legal and financial activities.

3. The staff of Ready Set Connect may use confidential information to provide you with appointment reminders or information related to treatment alternatives. Additional activities may include the assessment and design of program activities and/or to generate informational mailings. *A consumer may request to be removed from the Ready Set Connect mailing list by simply calling the privacy officer at 800.932.5837.*

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

5. We may disclose health information relative to adverse events with respect to product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement

6. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

7. 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), and, in certain situations, in response to a subpoena, discovery request or other lawful process.

8. We may disclose health information for the following specific government functions: a) health information of military personnel, as required by military command authorities; b) health information of inmates, to a correctional institution or law enforcement official; and c) in response to a request from law enforcement, if certain conditions are satisfied.

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 in this Notice. You may revoke this authorization, at any time, in writing, except to the extent that we have already relied upon your authorization in making a disclosure.

How We Will Protect Your Personal Health Information
1. Strict policies and procedures related to privacy will be followed when using computerized information, electronic mail, facsimile transmissions, voice mail as well as the storage of confidential records.

2. To protect personal health information from unauthorized or accidental release policies dictate the following:

   a. Your written consent or that of your legal representative (only) is required to release information to anyone not otherwise authorized by law to receive it.

   b. Requests for information related to mental illness, substance abuse, genetic testing results, HIV, or AIDS cannot and will not be released or re-released without a written consent from you or your legal representative.

   c. Our Business Associates, who receive protected health information, will be required to sign a Business Associates Agreement, which obligates them to follow procedures necessary to protect confidential identifiable health information and to use the information only for the stated purpose identified in the agreement.

Your Rights Regarding Your Health Information
1. You and/or your legal representatives may review the contents of your chart and obtain a copy (for a fee) after a written request is submitted. *All reviews of a consumer's chart will be conducted in the presence of a Ready Set Connect staff person.*

2. You are entitled to receive confidential communications of your protected health information by alternative means or at alternative locations. Please call the privacy officer to make such a request.

3. You and/or your legal representative may submit a written request to amend your protected health information to correct an inaccuracy or to improve clarity. All requests will be processed according to the organization's policies and procedures. Please note that Ready Set Connect is not obligated to agree to the requested amendment, but we are required to consider the request and inform you of our decision.

4. You and/or your legal representatives may obtain the disclosure history of your personal health information.

5. You and/or your legal representative may request, in writing, to restrict disclosures of personal health information, although Ready Set Connect is not obligated to agree to a requested restriction. We are however required to consider the request and inform you of our decision.

6. If you believe that your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Direct Complaints Regarding the Violation of Privacy Rights to:

Privacy Officer – Ready Set Connect

-or-

Secretary of the United States - Department of Health and Human Services

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This Notice was published and became effective April 14, 2003
ATECH Services reserves the right to amend this *Notice.* All changes will be made known to you via a revised *Notice.*

Ready Set Connect

Use and Disclosure of Information

I certify that I have received a copy of the ***Privacy Notice,*** dated April 14, 2003

Consumer: _____ **Date**: _____

OR

Legal Representative: _____ **Date:** _____

TO ENSURE THE TIMELY DELIVERY OF SERVICES THIS PAGE SHOULD BE SIGNED AND RETURNED TO READY SET CONNECT AS SOON AS POSSIBLE