1950 Keene Rd. Building K Richland, WA. 99352
Phone: 509-420-3442
Fax: 858-521-8173
www.childenrichmentcenter.org

Declaration of Child Enrichment Center's Professional Practices, Procedures, and Service Agreement

This document is designed to inform Child Enrichment Center Prospective Patients/Clients, Current Clients or Client's Family members about our background and ensure you understand our professional relationship.

AREAS OF EXPERTISE

Child Enrichment Center is the largest behavior health agency providing treatment services based in the principles of applied behavior analysis (ABA) for children with autism in the Tri-Cities, WA area since 2006. ABA is a scientifically validated approach to understanding behavior and how it is affected by the environment. ABA has been found to bring about meaningful and positive change in behavior for children with autism. Our programs are intensive, effective, and comprehensive. They are individualized to meet each child's needs. Our primary goal for each child is to maximize functional independence and quality of life by minimizing the core ASD features, facilitating development, as well as learning, promoting socialization, reducing maladaptive behaviors, and educating and supporting families. We provide ABA treatment services and family education in Spanish.

WHAT SETS US APART

- Multi-disciplinary approach
- Comprehensive curriculum
- Individualized teaching strategies
- Proven track-record of results

ASSESSMENT PROCESS

Developmentally appropriate ABA assessments will be used to identify strengths, weaknesses, and potential barriers to your child's ability to learn. The information derived from the assessment process is the foundation to developing an individualized ABA treatment plan for your child. Multiple assessment methods will be used across multiple informants including the following: file review, interview and rating scales, direct assessment and observation, aa well as assessment from other professionals.

SELECTING & MONITORING PROGRESS TOWARD TREATMENT GOALS

ABA treatment goals are identified based on the previously described assessment process. Goals are selected and prioritized based on your child's needs. The impact of those needs are in your child's environment (e.g., family, school, & community) as well as your child's health, safety, and overall well-being. Each goal will be specific, well defined in a measurable way, to allow frequent evaluation of progress toward a specific mastery criteria.

TREATMENT SERVICES

Autism Preschool (Day Treatment) for 2-5 year old's

Our intensive 1:1 behavioral treatment for young children is provided in a preschool setting designed to prepare each child to enter kindergarten with essential adaptive skills that enable improved independence. Communication, self-care including toilet training, behavior management, classroom skills, as well as fine & gross motor, and social and play skills are the areas of focus during our 4-day a week center-based educational program. Parent education and speech therapy are also offered weekly to help optimize treatment.

Basic ABA Treatment

After the child has completed the Autism Preschool program, progress continues in our basis treatment program offered 6-9 hours a week based on the child's individual 's needs and schedule.

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Social Skills Groups – Currently suspended due to COVID-19
CEC's after school social skills groups are small groups consisting of three to eight children. They are led by one of our trained licensed practitioners. We focus on helping children learn how to interact with others their own age. Group participants learn to communicate, develop new friendships, develop manners, problem solve social situations, pay attention to others, and control their emotions.

HOURS OF OPERATION FOR CENTER-BASED TREATMENT
Monday – Thursday 8:15 AM – 5:15 PM
Friday 8:15 AM – 11:30 PM

Holidays
Child Enrichment Center is closed on all Federal Holidays.

ATTENDANCE
Consistently attending scheduled ABA sessions is a critical component of treatment success. Child Enrichment Center reserves the right to discharge participants whose progress is impeded by chronic cancellations or absences.

Why is consistent attendance this important?
- Parent and participant involvement are a key component of our treatment services.
- Frequent contact with our clinicians is necessary to ensure consistency and integrity of our treatment plans and to ensure progress.
- Funders expect their participants to receive the recommended treatment on a consistent basis to achieve desired outcomes. We are required to document attendance as part of our participant's records and progress reports.
- Our clinicians reserve time in their schedules to be available to their participants. Typically, cancellations cannot be filled with other appointments without advance notice.

If you need to cancel a therapy session, please contact the center as soon as possible. Cancellations should be made 24 hours prior to the cancelled session, whenever possible. If we do not receive 24-hour notification (or in a reasonable amount of time considering the circumstances) of your cancellation, or you fail to show at an appointment, then you may be charged for the appointment without make up.

Cancellations must be made only in the case of a true illness (see attachment for symptoms and COVID-19 protocol) or family emergency. Vacations or other excused absences require at least two weeks of advance notice, with more notice given whenever possible. This allows our clinicians to reschedule and plan for the missed session time. Your child's ABA therapy schedule is carefully developed based on their needs, your availability, and the availability of your dedicated clinical team. Child Enrichment Center cannot guarantee requested changes to established schedules can be accommodated. We reserve the right to suspend or terminate services if cancellations and other schedule changes requests that do not align with our policies and procedures.

Inclement weather, including, but not limited to, snow, storms, icy roads, storm warnings and other emergent conditions may result in Child Enrichment Center closing or delay opening until conditions improve. All changes to our normal operating hours will be communicated to parents (and/or other caregivers as indicated by you on our contact list) via email, phone, and social media as soon as possible. In the event of inclement weather, we encourage you to use good judgment and not take undue risks to travel. Ultimately, the decision to send your child to Child Enrichment Center is yours. If you do decide to keep your child at home due to inclement weather when the center is open for operation, please contact us at (509-420-3442) or office@childenrichmentcenter.org a minimum of two (2) hours in advance of the schedule.

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If chronic unexcused absences or tardiness occur, a meeting will be scheduled to develop a corrective action plan to decrease future absences or tardiness. If additional absences or tardiness occur and/or a plan cannot be developed to ensure that your child is present for scheduled sessions, your child may be discharged from services.

PROVIDER CREDENTIALS/EXPERIENCE/EDUCATION REQUIREMENTS

Licensed Behavior Analyst (LBA) and Licensed Assistant Behavior Analysts (LaBA) are Master and Bachelor level practitioners licensed by the Washington State Department of Health (DOH). They provide assessments, develop treatment plans, provide direct treatment, and parent training. They supervise Certified Behavior Technicians (CBTs) and all other aspects of treatment services delivered to each child.

Certified Behavior Technicians (CBT) - CBTs are certified by the DOH to work directly with your child during scheduled treatment sessions, implementing ABA procedures and teaching plans as outlined by the LBA or LaBA.

PROFESSIONAL RELATIONSHIP LIMITATIONS AND RISKS

What we do

Behavior analysis is a unique method of treatment based on the idea that most important human behavior is learned over time and that it is currently maintained by consequences in the environment. Our job as behavior analysts and behavior technicians is to work through behaviors you would like to change and which are socially important to your child.

As behavior analysts and therapists, we do not make judgments about behavior. We try to understand behavior as an adaptive response (a way of coping) and suggest ways of adjusting and modifying behavior, reduce pain and suffering, and increase personal happiness and effectiveness.

Please know that it is impossible to guarantee any specific results regarding your goals. However, we will work together to achieve the best possible results. If we believe our services have become non-productive for your child, we will discuss terminating services and will provid referral information as needed.

GENERAL BEHAVIOR RECOMMENDATIONS:

The most important principle that will improve your relationship with your child and improve the overall functioning of your child in all areas: is for you (the parents) to provide plenty of positive reinforcement following behaviors you want your child to do more. Follow through with requests and demands you impose upon your child. Be constructive with your feedback when correcting your child's problem behaviors and use simple, age appropriate communication.

FAMILY'S ROLE IN THERAPY

The involvement of the family is critical in the treatment process. No one knows your child better than you (the parent). You are ultimately the one who cares the most and are most affected by your child's challenges and strengths.

With your input, we can help you discover what is maintaining your child's problem behaviors (including the symptoms of autism), discover more appropriate replacement behaviors, and help us teach your child new functional skills and behaviors. We can help you acquire new behaviors to improve your skill level. You will be consulted at each step of the process. We will ask you about your goals for your child, and we will explain our assessment process and assessment results as plainly as possible. We will describe our plan for intervention or treatment and ask for your approval of your child's individualized treatment plan.

Our goal is to teach parents to generalize what the practitioners do during treatment into everyday living situations. Watch and learn from your practitioners. Access as much parent training as you can. Your involvement will optimize your child's treatment, furthering their progress. However, you are not expected to be the therapist to your child. Our practitioners can

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provide the "intensive" teaching. This will allow you to have some respite and will make your time with your child more enjoyable and productive. Outings to the park, shopping, visiting family and friends, dressing, bath time, and dinner are just a few of the daily routines that serve as opportunities for parent teaching, using the principles of Applied Behavior Analysis (ABA).

PARENT/CLIENT RESPONSIBILITIES

It is the parent's responsibility to inform practitioners of their child's behavioral concerns, answer questions about their child's behavior honestly, and report any and all medical conditions, changes in health, diet, sleep, family circumstances, and/or insurance plan or coverage...etc. These variables may change or affect your child's response to treatment. See Exhibit C: Client's Responsibility. It is also the parent's responsibility to receive regular recommended parent training/education in behavior analysis and the treatment protocols specifically outlined for your child.

SUPPLIES

If your child attends the Autism Preschool or our Day Treatment program or is at our center for more than 2 hours per session, it is required that you supply your child with snacks. A supervisor will assign snacks on a monthly basis and will let you know in advance. Children who are toilet training or are not completely toilet trained will need to provide extra underwear and/or pull-ups/diapers and at least one change of clothing in a backpack that will be sent home daily.

PROFESSIONAL RELATIONSHIP

Under our compliance code of ethical conduct outlined by the Behavior Analysis Certification Board (BACB), we are not allowed to work with you in any other capacity except as your behavior analyst or treatment provider at Child Enrichment Center. In addition, our providers and practitioners are under a legal agreement to abstain from soliciting our clients during employment of, or after termination with Child Enrichment Center.

CLINICAL SUPERVISION

All practitioners abide by a subset of the BACB's Professional and Ethical Compliance Code for Behavior Analysts.

Certified Behavior Technicians (CBTs) receive ongoing supervision by a BCBA or LBA supervisor for a minimum of 5% of the hours spent providing applied behavior-analytic services per month (including at least 2 face-to-face synchronous supervisory contacts).

Client/case supervision activities can be described as those that involve contact with the client or caregivers (direct supervision, also known as clinical direction) and those that do not (indirect supervision). Both direct and indirect case supervision activities are critical to producing good treatment outcomes and are included in our treatment services. It should be noted that direct case supervision occurs concurrently with the delivery of direct treatment to the client. On average, direct supervision time accounts for 50% or more of case supervision.

Direct Supervision Activities

- Directly observe treatment implementation for potential program revision
- Monitor treatment integrity to ensure satisfactory implementation of treatment protocols
- Directing staff and/or caregivers in the implementation of new or revised treatment protocols (client present)

Indirect Supervision Activities

- Develop treatment goals, protocols, and data collection systems
- Summarize and analyze data
- Evaluate client process towards treatment goals

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- Adjust treatment protocols based on data
- Coordination of care with other professionals
- Crisis intervention
- Report progress toward treatment goals
- Develop and oversee transition/discharge plan
- Review client progress with staff without child/client present to renew treatment protocols
- Directing staff and/or caregivers in the implementation of new or revised treatment protocols (client absent)
- Group training and case review

Data Collection & Graphing

One of the unique aspects of behavior analysis is that as a form of treatment, decisions are made based on objective data collected during ABA therapy sessions. In the beginning, and throughout the treatment process, we will take baseline data to first determine the nature and extent of the behavior problems that we are dealing with. We will then devise an intervention or treatment to continue to take data and determine if it is effective. We will show you this data and make changes in treatment based on this data.

We will need a list of prescribed or over-the-counter medications and/or supplements in addition to any medical or mental health conditions, so we can include such information into our analysis of your child. This information is kept confidential.

CONFIDENTIALITY & HIPAA

Your child (the clients) and their practitioners have a confidential and privileged relationship. We do not disclose anything that is observed, discussed, or related to your child without written consent. In addition, we limit the information that is recorded in your child's file to protect privacy. We need you to be aware that confidentiality has limitations as stipulated by law including the following:

- Child Enrichment Center has your written consent to release information.
- Child Enrichment Center is verbally directed by you to tell someone else situations.
- Child Enrichment Center determines that you or the child is a danger to yourself or others.
- Child Enrichment Center has reasonable grounds to suspect abuse or neglect of a child, a disabled, or an elderly adult.
- Child Enrichment Center is ordered by a judge to disclose information.

Attached Exhibits: Incorporation by Reference (Copies of these completed and signed forms are in your child's file.)

1. Consent to Provide Services attached as Exhibit A;
2. Client Rights attached as Exhibit B
3. Client Responsibilities attached as Exhibit C;
4. Complaint Form attached as Exhibit D;
5. Consent to Video record and Photograph Release From as Exhibit E;
6. Clinical Record Content and Acknowledgment Form as Exhibit F;
7. Note of Privacy Practices Form and Notice of Receipt attached as Exhibit G;
8. Consent to Release or Obtain Information attached as Exhibit H.

OTHER THERAPIES

Findings from several studies show that an eclectic model, where ABA is combined with non- evidence-based treatment, is less effective than ABA alone. Therefore, treatment plans that combine ABA with additional procedures that lack scientific evidence as established by peer- reviewed publications should be considered eclectic and do not constitute ABA

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treatment.

If you are currently involved with other therapies, please let us know. If, during the course of our treatment, you should contemplate starting other therapies please let us know immediately, so we can discuss the implications. Other therapies may or may not interfere with a child's response to evidence-based treatment progress.

TERMINATION OF SERVICES

Interruption of services refers to the *stopping* of services for more than a month at a time.

Discontinuing services means that the client or parent is terminating services for good and services will no longer be provided to the child as outlined in this initial service agreement.

You have the right to terminate our services at any time; provided, however, that in such event, the balance of fees, co-pays, deductibles, etc. shall become immediately due and payable by you. Upon termination, failure to immediately pay for services already rendered by Child Enrichment Center constitutes breach of the Agreement.

We also have the right to terminate our services with you at any time. We reserve the right, at our discretion to terminate our services and resign our engagement in the event that:

1. Statements or fees are unpaid (in whole or in part) after 30 days of billing statement
2. There is reported mistreatment of CEC staff members
3. There is failure to follow through with treatment protocols and recommendations that affects your child treatment services
4. There is no show for appointments or session times more than 3 times
5. You excessively cancel sessions for purposes other than medical issues with your child (doctors note required for more than 5 consecutive sessions cancelled)

You expressly agree and consent to our right to terminate and resign as set forth in this paragraph upon signing this service agreement.

A Transition, Aftercare or Discharge Plan will be provided for all cases terminated to ensure the child has a plan to continue on with effective treatment services elsewhere.

TRANSITION OF SERVICE POLICY

Child Enrichment Center requires a notice of 30-days to provide an appropriate written Transition Plan for your child to receive ABA services elsewhere. Our practitioners will use the 30-day period to review, prepare, and report your child's assessment results, treatment data, progress, and most recent treatment goals in written report, along with all other previous treatment plans as requested, that can be provided to the new service provider. Child Enrichment Center does not provide our ABA Program Sheets and/or teaching curriculum to other companies as our approach or treatment method is proprietary information.

Transitioning or Fading out of ABA Services

The supervisor of your child's treatment will provide a fade out policy that explicitly states the conditions that qualify your child for a fade out of services (e.g. the child is no longer benefitting, child no longer requires the services, child requests discontinuation, relocation, child violates terms of client-services agreement, etc.) In addition, the plan may include details such as discharge date, rate of fade out (e.g. Decreasing frequency of sessions from once per week to once every two weeks), resources provided for addressing remaining areas of deficit and for many cases specific follow-up consultations our practitioners can provide to troubleshoot issues that may arise during the transition or

termination.

SUBMITTING COMPLAINTS

Parents and clients can submit a written compliant to our office by using the "Complaint Form" or Exhibit D in this packet. Complaints can be submitted by emailing a secure and confidential email account: office@childenrichmentcenter.org

Please provide and document all necessary details about the problem. With written details about the problem or complaint, we will contact you about the issues confidentially. We will strive to work out or resolve these issues without it affecting your child's therapy in any way. We ask that parents do their part to communicate problems they see early on so they can be resolved before more serious issues arise.

LANGUAGE ASSISTANT PROGRAMS

Translation services will be provided by Universal Language Service.

FEES & PAYMENT

All parents/clients are expected to contribute to the cost of therapy regardless of the type of insurance you have, subject to change.

Your insurance may be billed for the following services and fees listed:

- Initial Intake, Behavior & Skills Assessment, & Individualized Treatment Plan. This will be billed at $200 per hour
- Ongoing assessment, individual curriculum development, evaluation, & reporting, billed at $200 per hour
- Autism Preschool/Day Treatment, billed at $506.92 per day
- Direct 1:1 basic ABA Treatment, billed at $100 per hour
- Supervision, consultation, and parent education services, billed at $200 per hour
- Initial speech evaluation/assessment, billed at $350
- Ongoing speech assessment & other services, billed at $200
- Group treatment: social skills, billed at $100 per hour (with 1:1 support) or $75 per hour (without 1:1 support)

INSURANCE BILLING POLICIES

Clients are financially responsible for all outstanding charges. Parents will be billed for Co-Pays, Deductibles, and all other outstanding balances and payments must be received no later than 30-days after invoice date. An invoice will be sent by email after billing statement and/or payment is received by the insurance company. Some insurance companies are more difficult to work with than others regardless of our contracts with them or having pre- authorizations for services. Insurance companies can deny services for many reason. A pre-authorization for services from an insurance company is not a guarantee of payment. We do not receive denied claims until 30-days or more after the services have been provided.

If your insurance company denies claims or will not process our claims and the problem persists, regardless of doing all we can do to resolve the issues, CEC will file a formal complaint with the insurance company. Termination or suspension of services may be recommended until payment issues are resolved. CEC will provide you a 30-day notice if this occurs and providers will work to outline an alternative plan to resolve payment issues. You can be helpful in resolving issues with your insurance company by communicating with them. Insurance companies are more likely to work with the beneficiaries they collect money from than the providers they pay.
Please contact our office for any questions regarding co-pays, co-insurance, and deductibles:
Email: office@childenrichmentcenter.org

Phone#: 509-420-3442
All payments should be sent or received at:
Child Enrichment Center
1950 Keene Rd, Building K
Richland, WA. 99352

LATE PAYMENTS

It is our policy to charge a $25 processing fee plus interest at the rate of eighteen percent (18%) per annum, compounded annually (to the extent permitted by law), on any sums not paid within thirty (30) days of the initial billing date, with a minimum late payment penalty, including the finance charge, of $25.00 per month. Of course, if the invoice is paid on timely basis, no interest or late payment will be charged. If any bills remain unpaid for more than thirty (30) days, Child Enrichment Center shall have no further obligation to perform services under this agreement.

FEES DISPUTES; RIGHT TO ARBITRATION

If any legal action or proceeding is brought by any party to this agreement against the other party to enforce the provisions of this agreement, the prevailing party is entitled to recover reasonable attorney's fees and cost of suit in addition to any other relief to which the prevailing party may be entitled. In addition, you should know that you have the right to have any dispute concerning fees submitted to mandatory binding arbitration. Such arbitration shall be conducted in accordance with rules of the State Bar Association of Washington, before an arbitrator or arbitrators selected in accordance with those rules. The decision of the arbitrator(s) shall be final and binding on the parties. The arbitrator(s) shall have the discretion to order the cost of arbitration, including his fees, other cost, and reasonable attorneys' fees. These costs shall be borne by the losing party.

ENTIRE AGREEMENT

This Agreement constitutes the entire agreement between the parties. It may not be modified except in writing signed by both parties.

DISCLAIMER

You agree that your use of our service(s) is solely at your own risk. You agree that all of such services are provided on an "as is" basis and "as available" basis, except as otherwise noted in this Agreement. Child Enrichment Center expressly disclaims all warranty of merchantability, fitness for particular purpose, and non- infringement.

LIABILITY

In no event, will Child Enrichment Center be liable to the client or any third party for any damages, including personal injury, medical expenses, loss of wages, loss of profits, or other incidental or consequential or special damages arising out of the operation, performance, instruction, therapy, training, consultation, supervision, service, participation, application, coordination, and any other factor relating to the ABA treatment/therapy/consultation sessions provided by Child Enrichment Center.

PARTIAL INVALIDTY

The unenforceable, invalidity or illegality of any provision of this Agreement shall not render the other provisions unenforceable, illegal, or invalid.

GOVERINING LAW

The agreement shall be governed by and construed in accordance with the laws of the State of Washington or in any other state to which services are provided.

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Exhibit A

Consent to Provide Service Agreement to Terms and Conditions of Engagement

Child's Name:_____ DOB:_____

Name and address of Agency to provide services:
Child Enrichment Center
1950 Keene Rd Building K, Richland, WA 99352

Service Proposed: (Please check the boxes next to the services you will be receiving with CEC)

- ☐ Autism Preschool (Day Treatment)
- ☐ Basic ABA Treatment
- ☐ Social Skills Group
- ☐ Parent Education/Consultation

Benefits, risks of proposed services:

- Benefits - Services may lead to reduction of symptoms
- Risks - Symptoms may worsen before improving or may not improve at all
- Alternatives - No service or the use of other types of services
- Anticipated results - Services will improve the possibility of positive outcome

For the person(s) providing consent:

- I hereby consent to the services proposed above for my child.
- I was able to ask questions and receive these proposed services.
- I understand that I may withdraw my consent at any time with written notice.
- I understand that the anticipated results of services are not guaranteed and are based on following recommendations of supervising clinicians.
- I understand that certain records about my child's services shall be kept in written or computerized form.
- I understand that records about my child's services may be audited and used for evaluation and research with full protection of confidentiality.

_____
Printed name of Parent/Legal Guardian providing consent and relationship to child.

I, _____, as Parent or Legal Guardian of, _____, state that I have read and understand the foregoing terms and conditions of engagement and agree to pay Child Enrichment Center for services in accordance with those terms and conditions. This agreement will become effective upon the date signed below, but it will be retroactive to the date that services were first provided by Child Enrichment Center.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Signature of Child Enrichment Center Representative Date

(Copies of these completed and signed forms are in your child's file)

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Exhibit B

Client Rights

Child's Name:_____ DOB:_____

Parent/Legal Guardian:_____ Relationship:_____

I understand that my child's rights are:

1. To be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises',
2. To receive services in the least restrictive, feasible environment,
3. To be informed of available program services,
4. To participate in the development, review, and revision of one's own individualized treatment plan and receive a copy,
5. Develop a plan of care and services which meets your unique needs,
6. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, or photographs,
7. To receive services of a certified language or sign language interpreter and written material and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act,
8. To refuse any proposed treatment, consistent with the requirements in chapter 71.05, 71.12 and 71.34 RCW,
9. To receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability,
10. To practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice,
11. To be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited-English proficiency, and cultural differences,
12. To be free of any sexual exploitation or sexual harassment,
13. To be free of exploitation, including physical and financial exploitation,
14. To review your clinical record and be given an opportunity to make amendment or corrections,
15. To receive an explanation of all clinical recommendations, including expected effect and possible side effects,
16. To have all clinical and personal information treated in accord with state and federal confidentiality regulations,
17. To receive a copy of agency grievance system procedures upon request and to file a grievance with the agency if you believe your rights have been violated,
18. To submit a report to the department when you feel the agency has violated a WAC requirement regulating behavioral health agencies,
19. To make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions,
20. To, as a parent of a minor patient, observe any and all ABA sessions with your child and ask questions,
21. To, as a parent of a minor patient, to terminate any procedure which you might object to. Such intervention will not be reinstated without your approval,
22. To receive a treatment plan and verbal explanations of our interventions in language you can understand, free of professional or academic terms and language not understandable to the lay person,
23. The right to be informed of the reason(s) for denial of a service,
24. The right to know the cost of services, and
25. The right to be informed of all client rights and exercise any and all rights without reprisal in any form.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Signature of Child Enrichment Center Representative Date

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Exhibit C
Client Responsibilities

Name of Child:_____ DOB: _____

Parent/Guardian Name (completing this form): _____

Clients who are using this service have a responsibility to:

1. Respect everyone involved in the services.
2. Respect the rights of others including their rights to confidentiality and privacy.
3. Inform staff of support needs.
4. Read, understand, and agree to the Parent Agreement/Contract agreement before signing.
5. Honor agreements made with CEC about services provisions and care.
6. Respect CEC property.
7. Let the therapist or center know if you are not available for an appointment.
8. Ensuring that you are not under the influence of alcohol or other drugs, and/or behaving in a way which makes delivery of service difficult or dangerous.
9. Act in a way which respects the rights of other clients and staff.
10. Inform practitioners of any major changes to client including but not limited to; relocation, medical care, health, sleep disturbances, diet changes, medication changes, family crisis, parent employment changes, address/ health insurance changes, school/educational placement transitions or changes, or any other significant event or conditions that may affect the way the client responds to treatment or any third-party involvement affected.
11. Take responsibility for the results of any decisions they make.
12. Seek a fair resolution of any complaints.

Any client who has reason to believe that he/she has been mistreated, denied services, or discriminated against in any aspect of services because of disability may file a grievance with the Washington State Health Department:

Health Systems Quality Assurance Complaint Intake
P.O. Box 47857
Olympia, WA. 98504-7857
Phone: 360-236-4700
Email: HSQAComplainIntake@doh.wa.gov

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature Child Enrichment Center Representative Date

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Exhibit D
Compliant Form

Name: _____

Address: _____

Phone Number Home:_____Cell:_____

Follow Up Requested: Yes_____ No_____

INCIDENT DESCRIPTION
Type of complaint (billing, payroll, clinical/therapy, staff professionalism, etc.):_____

_____

_____

_____

What happened? Time:_____Date:_____Location: _____

_____

_____

_____

Injury involved:

_____

_____

_____

Fax within 24 hours to: 1-858-521-8173 (all complaints will be handled confidentially and discreetly)

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Exhibit E
Clinical Record Content

A clinical record shall be maintained for every individual evaluated and/or treated by Child Enrichment Center.

The clinical record will include:

1. Parent contract-parent policies and procedures signed and dated. Make sure the family has a copy of the contract.
2. Child information (demographic)-child information and treatment record information, behavioral health and family history form, and ABA therapy schedule form.
3. The initial assessment plan, 6-month treatment plan update/report, VB-MAPP assessment, and any other assessments.
4. Other pertinent information, if applicable; i.e. diagnosis report and doctor referral, medial and laboratory records, school records, speech and OT records, court order for treatment record, authorizations from insurance, referral form (from CEC to another company), and discharge, terminate, transition, aftercare plan.
5. Documentation of individual's responses to questions regarding if the individual is currently under department of correction (DOC) supervision, if the individual is under civil or criminal court ordered mental health, or substance use disorder treatment and if there is a court order exempting the individual participant from reporting requirement. If yes to any of the above questions, documentation that Child Enrichment Center notified DOC, a copy of the court order, and when appropriate any request for an evaluation by a designated mental health professional if a violation of the court order has occurred and the violation concerns public safety.
6. Documentation of progress towards treatment goals established in the treatment plan.
7. Documentation of any confidential information that has been released without the consent of the individual under RCW 70.02.050, HIPPA, 70.02.230 and 70.02.240 if the individual received mental health treatment services.
8. Documentation that the individual has been advised of the limits of confidentiality in the event that abuse, neglect, or exploitation is suspected.
9. Documentation of informed consent to treatment by the individual or the individual's parents. If court ordered, documentation of the detention or involuntary treatment order.
10. Documentation of coordination of care, as needed.
11. Documentation of all service encounters such as progress notes.
12. Documentation of completed authorizations for release of information.
13. Copies of applicable correspondence.
14. Documentation of discharge information.

Clinical Record Content Acknowledgement of Receipt

I_____hereby acknowledge that have received and reviewed a copy of the Child Enrichment Center's Clinical Record Content policy which lists the items that are kept in my or my child's file.

Child's Name (please print): _____

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Child Enrichment Center Representative Date

(Copies of these completed and signed forms are in your child's file)

1950 Keene Rd. Building K Richland, WA. 99352
Phone: 509-420-3442
Fax: 858-521-8173
www.childenrichmentcenter.org

Exhibit G
Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective ____/____/____ and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use, and disclosure of your health records:

1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain.
4. Individual's clinical records will be maintained by our office for a minimum of six years after the discharge date or at least three years after the clients eighteenth birthday.

All changes in the notice will be prominently displayed and available in our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or health care operations requires you to sign an Authorization. Certain disclosures are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith, to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential health information for the following purposes. Primary care physician, teachers, speech therapists, occupational therapists, para-educators, …etc. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre- certification and pre-authorization of services, or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions. There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law- enforcement activities,

judicial administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases, or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law-enforcement officials' information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

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

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you. Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time.

In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain rights regarding your health record information, as follows:

1. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
2. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except

with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

3. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
4. You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information
5. All requests for inspection, copying, and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
6. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment, healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
7. If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice for your personal records.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.3

All questions concerning this Notice or requests made pursuant to it should be addressed to PRIVACY OFFICER, 1950 Keene Rd, Building K, Richland, WA 99352

(Keep for your files)

1950 Keene Rd. Building K Richland, WA. 99352
Phone: 509-420-3442
Fax: 858-521-8173
www.childenrichmentcenter.org

Receipt of Notice of Privacy Practices

Child's Name: _____ Date of Admission (today):_____

My signature on the form acknowledges that I have received Child Enrichment Center's Notice of Privacy Practices. I understand that this document explains the ways Child Enrichment Center may use or disclose my child's personal information and my child's rights with respect to my child's service information.

I have been provided with the opportunity to discuss any concerns about the privacy of my child's information Child Enrichment Center has during the provision of services.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Child Enrichment Center Representative Date

(Copies of these completed and signed forms are in your child's file)

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Exhibit H

Consent to Release and/or Obtain Client Information

This consent form is designed to allow us to exchange information with other health care providers involved in the client's care. This will allow us to either obtain relevant records to help us provide thorough and complete care to the client and/or allow us to share records with other providers in order to coordinate care.

Client's Name: _____DOB: _____Telephone #: _____

☐ Obtain Information ☐ Release Information

The purpose of this disclosure:
☐ Coordination of Care
☐ At Client/Parent Request
☐ Other (specify): _____

This authorization expires on (insert date): _____

Note: If no expiration date is listed above, this authorization if valid for one year from the date on which it is signed.

Outside Provider Contact Information

Name of Provider: _____

Organization: _____

Address: _____

Phone: _____Fax: _____

Email: _____

☐ Obtain Information ☐ Release Information

Information that is authorized to be released or obtained from the above provider: (Please check all boxes that may apply)

☐ Treatment Summary ☐ Progress Notes ☐ Assessment Results
☐ Verbal Disclosure ☐ Evaluation Report ☐ Psychological Testing
☐ Medical/Health Information ☐ Individual Education Plan (IEP)
☐ Past or Present Treatment/Service Plans ☐ Other: _____

POTENTIAL FOR REDISCLOSURE: Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information.

REVOCATION: I understand that I may revoke this authorization by submitting the revocation request in writing to the Child Enrichment Center Privacy Office, 1950 Keene Rd, Building K, Richland, WA 99352, at any time. Any revocation will not be effective to the extent that action has already been taken based on the original authorization, or where the Child Enrichment Center requires the information in order to be paid for treatment provided to me.
By signing,

1950 Keene Rd. Building K Richland, WA. 99352
Phone: 509-420-3442
Fax: 858-521-8173
www.childenrichmentcenter.org

I acknowledge that I have read and agree to all the conditions specified in the consent form. I acknowledge that permission I give permission to Child Enrichment Center to release and obtain the information with specified providers as stated above and further understand those who receive this information cannot disclose it to others unless permitted by state law.

This consent was made freely, voluntarily and without coercion. I was able to ask questions and receive answers about this release.

I hereby authorize releasing and obtaining the information as specified above and further understand those who receive this information cannot disclose it to others unless permitted by law.

I understand the risks and benefits of disclosure:

- Benefits – Appropriate sharing of necessary information important for services
- Risks- Loss of confidentiality

I understand that I have the following rights:

- To inspect or to receive a copy of my protected health information,
- To receive a copy of this signed authorization and
- To refuse to sign this authorization

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Child Enrichment Center Representative Date

_____ _____

Signature of Client (If 13 years or older Date

(Copies of these completed and signed forms are in your child's file)