ABA CHECKLIST

Revival Therapy
3145 E Warm Springs Rd Suite 400
Las Vegas, NV 89120
FAX 702-944-5498

David Wier, BCBA
Director of ABA Program
Referrals@RevivalTherapyVegas.com

The following documents are required to qualify for and be placed on the Revival Therapy ABA waitlist AND to receive services.

1. FA11F Form completed by and signed by a Medicaid Physician. This form must be printed and physically filled out, and signed by physician.
2. Testing reports or related material to show diagnosis of client. Diagnoses accepted: FASDs, ASD, ADHD (need report for severity), and other neurological conditions. (*the more testing material provided from qualified professionals, the better the likelihood of approvals).
3. Signed consent forms for Revival Therapy, least restrictive environment agreement, and Cancellation Policy.
4. Completion of demographics form (This Page).

Part 1 and 2 can be faxed directly to us at 702-944-5498.
Part 3 and 4 can be emailed directly to us at Referrals@RevivalTherapyVegas.com

Placement on our waitlist will occur once ***ALL*** of the above materials are received. Until all materials are received, client will be placed on an interest list.

Demographics:

Client Name:
Client Date of Birth:
Client Medicaid Number (FFS Only):
Client Gender:
Preferred Provider Gender (cannot be guaranteed):

Caregiver Name:
Caregiver Phone Number:
Caregiver Email:

Current Diagnosis Qualifying for ABA Services:
Languages Spoken in the Home:

Preferred In Home or Clinic:
Home Address:

Availability (times) for Services:
Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday:

REVIVAL THERAPY

CLIENT CONSENT FORM

Client Name:

Medicaid Number: | Date of Birth:

Address:

City/State/Zip Code:

CONSENT AGREEMENT

- Consent to evaluate and treat: I voluntarily consent that my child, my family, or myself will participate in a mental health and/or occupational therapy evaluation and/or treatment through Revival Therapy (RT). I understand that the evaluation and/or treatment will be provided with complete and accurate information in the following areas including: the benefits of proposed treatment, alternative treatment modes and services, the manner in which treatment will be administered, expected side effects from treatment and/or risks of side effects, probable consequences of not receiving treatment. Treatment will be administered by a Licensed Clinical Social Worker and/or an Occupational Therapist; via supervised MSW/BSW/MFT or student therapist; OR Occupational Therapist Assistant/Occupational Therapy Student, BCBA, BCaBA, or RBT. Students may also be observing sessions in order to obtain professional experience/certification or licensure.
- By signing this form, I understand and acknowledge that I have no obligation to obtain both behavioral health and occupational therapy and ABA through Revival Therapy. I acknowledge that receiving these services through RT is not a requirement to receive treatment via RT and these services are not contingent upon one another to obtain treatment through RT. Furthermore, I acknowledge that I have the right to choose a provider and can terminate services anytime.
- Charges: Fees are based on the type of evaluation and services provided. I am responsible for charges at the time of service and responsible for all charges not covered by insurance.
- Confidentiality, Harm, Inquiry: Information from my evaluation and any treatment is contained in a confidential medical record at RT and I consent to disclosure for use by Revival Therapy staff for the purpose of continuity of care. Per Nevada mental health law, information provided will be kept confidential with the following exceptions. 1. If the identified client is deemed to present a danger to themselves or others. 2. If there are concerns about abuse or neglect. Or 3. If a court order is issued to obtain records.
- The Right to Withdraw Consent: I have the right to withdraw my consent for the evaluation and/or treatment at any time by providing a written request to Revival Therapy.
- For families experiencing separations, divorce, etc., both parents/guardians must consent to treatment of their child. If there is a custody agreement in place, a copy of the order must be provided to RT in order to ensure all necessary parties are provided informed consent for treatment. In cases where only one consenting party is required, a copy of this agreement will be needed for the client chart. ***Failure to provide adequate information for consent to treatment will result in immediate discharge from all services.***

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I understand that I have the right to ask questions of my service provider about the above information at any time

Please check the following that apply:

- ☐ Consent to receive text messages and emails.
- ☐ Consent to receive therapy services via Telehealth.
- ☐ Consent to confidential information to be provided to court or attorney
- ☐ Consent to request treatment records from Revival Therapy
- ☐ Consent to go into the school and release information regarding the client
- ☐ Consent to be transported by Revival Therapy staff
- ☐ I have a custody agreement to provide and require additional signatures for consent to treatment

Client or Guardian Signature **Date**

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REVIVAL THERAPY

CLIENT CONSENT FORM

Client Name:

Date of Birth:

Guardian/Caregiver Name:

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION PURSUANT HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

ACKNOWLEDGMENT

I authorize REVIVAL THERAPY to disclose the personal information of myself (or information of my child) consisting of mental health evaluations, treatment planning, and/or updates to the following entities:

Please check the following that apply:

- ☐ Insurance companies for requesting medical record information and billing
- ☐ Confidential information to be provided to court or attorney upon request (dated permission required)

Client or Guardian Signature **Date**

TREATMENT PLANNING ACKNOWLEDGMENT

I participated in the development of the treatment plan and understand that the goals within this plan will be addressed as part of treatment. I further understand that treatment is a collaborative process and I am able to assist in the modification of goals if so desired or if deemed necessary. I understand that I have a choice in servicing providers and that these services have been determined to be consistent with the regulatory definitions set forth by my insurance provider, if covered by insurance.

Client Signature **Date**

Client or Guardian Signature **Date**

REVIVAL THERAPY

CLIENT CONSENT FORM

CANCELLATION-MISSED APPOINTMENT POLICY

A therapeutic relationship is built on mutual trust and respect. As such, every effort will be made to be on time for your scheduled appointment, and ask that you give the same courtesy of a call or text when you are unable to keep your appointment. Please read, sign, and date the cancellation and missed appointment policy below.

A cancelled appointment hurts three people: you, your therapist, and another client who could have potentially used the time missed. Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is cancelled without adequate notice, we are unable to fill this time slot by offering it to another current client, a client on the wait list, or a client with a clinical emergency. Without a cancellation fee policy in place, your therapist will lose the opportunity to schedule another client if you late cancel or do not show up.

Clients can cancel or reschedule an appointment anytime, if they provide at least 24 hours' notice. Rescheduled sessions must fit the therapist's schedule first and foremost. 3 non-consecutive rescheduled appointments may also result in discharge or being placed back on the waitlist as clients are provided with scheduling options based upon current openings offered by their assigned therapist (these are usually scheduled the same day/time weekly). If you cancel an appointment with less than 24 hours' notice, or fail to show up, you will be charged the total fee for the appointment (cash pay clients), or you will be reminded of this policy and given notice of a possible discharge from sessions (3 non-consecutive no-shows or late cancellations). Some practices have a 48-hour policy. Some even have a 72-hour policy. Ours is 24 hours, and we are firm at 24 hours. For Saturday or Sunday appointments, 48-hour notice is required. Our cancellation policy in not a penalty or a punishment. Most clients understand this. Very rarely, there will be a client who will feel that they are being punished when they are charged a late cancellation fee. We want to make sure that you don't feel this way, if someday you miss an appointment.

It is likely that at some point you might forget about an appointment, or something will come up in your schedule that will result in you missing an appointment. Maybe you'll need to work late or maybe you'll get a sudden onset of the flu. Maybe your kids will have doctor's appointments, or your car will break down, or something unavoidable will come up. We are not upset with clients when they miss an appointment. We understand life happens. In return, our clients understand that scheduling an appointment with one of us is like buying a ticket to an event. If you miss the event, it doesn't matter why you missed it, or even if it was your first time, you can't turn in your tickets for a refund.

You can cancel your appointment by calling, texting, or emailing your therapist. If you are more 10 minutes late to your appointment time, it will be treated as a late cancellation and this policy will apply. Being 10 minutes or more late to your appointment WILL result in the session being cancelled (cash pay AND insurance clients), meaning your session will not be held even if you show up 20 minutes into the session. For insurance clients, it is important to note that our therapists have pre-approved billing codes based upon the minutes within a session held. After 10 minutes, they cannot bill the codes within insurance, resulting in the full cancellation of the session as billing cannot be completed. Clients who are unsure if they can commit to therapy appointments scheduled for them should discuss possible referral options with the therapist or administrative team, OR ask to be provided with an alternative scheduling option (biweekly or even monthly sessions). Because your therapist believes that the responsibility for your care is on both the client and the therapist, we agree that if you are double-booked for an appointment or if we miss an appointment without notice you will receive a FREE therapy session.

- ***If you are unable to keep a scheduled appointment, please contact your therapist with at least 24 hours in advance (If your appointment is 1pm on Tuesday, notice should be provided no later than 1pm on Monday). For Saturday or Sunday appointments, 48-hour notice is required. There is a 10 minute cancellation window for your session being considered 'cancelled' if tardy.***
- ***For our cash pay clients: If you fail to notify your therapist with a minimum of 24 hours in advance of the cancellation and you miss your appointment, you will be charged the full fee for the session.***
- ***At the time of cancellation, another appointment will be offered based upon the therapist's scheduling availability.***
- ***Three (3) missed appointments - they need not be consecutive - will result in an administrative discharge from the practice OR placement back on our waitlist. For ABA clients, 10 hours of cancelled or missed appointments during an authorization will result in discharge of services.***

Client or Guardian Signature **Date**

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REVIVAL THERAPY

CLIENT CONSENT FORM

LEAST RESTRICTIVE ENVIRONMENT FOR TREATMENT AGREEMENT

Revival Therapy is committed to providing quality and caring treatment services to meet our clients' needs. In order to maintain effective services we offer sessions within the least restrictive environment, which includes in home therapy. In home therapy is also convenient for families since we travel to the client's residence. In order to begin in home services, it is important to create a home environment that optimizes treatment. Therefore, below are requirements to ensure clients receive the best possible outcomes and our therapists work in a safe and conducive environment.

Please initial all below as an agreement to obtain these services:

..... There must be an adult (18 years or older) within the residence at all times

..... The treatment area inside the residence will be well lit

..... Due to possible allergies and the safety of our therapists, animals will be put away or removed from treatment area

..... Treatment area will be clean and ready for sessions prior to therapist's arrival

..... Client will be on time for sessions

..... Television and music will be turned off within treatment area to avoid distraction

..... Unless otherwise requested by therapist, siblings or peer family members will not be in session area to limit distractions

Client or Guardian Signature **Date**

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