For Office Use Only

Registration Packet:

- Birth Certificate & Social Security Number
- Immunization Certificate
- Medical Release
- Medical Info Release
- HIPAA Privacy
- Medication Release & Medication Distribution Release
- Medical Plans:
  - ☐ FORM F-1- Asthma
  - ☐ FORM F-2- Diabetes
  - ☐ FORM F-3 – Seizure
  - ☐ FORM F-4- Food Allergy
- Parent/guardian, Family, Medical & Emergency Info
- Payment Policy
- Medicaid Patient Cap Policy
- Proposed Aging/Collection Policy
- Authorized Signature & Financial Info
- Authorization & Release
- Authorization to File Claims
- Assignment of Benefits
- Health Insurance Coverage & Payment Policy
- Automatic Account Withdrawal
- Voided Check (if ACH)
- Photo/Media Release Form
- FBA (Functional Behavioral Assessment) Form
- SCM (Safe Crisis Management) Form

REGISTRATION PACKET
2021-22

BLUEGRASS CENTER FOR AUTISM
Teach to Learn. Learn to Live.

Name of Child: _____
(First) (Middle) (Last)

Child's Date of Birth: _____ Child's Age: _____ Child's Sex: M F

Child's Address: _____
(Street) (City) (State) (Zip Code)

Parent's Cell (main) Phone: _____

Child's Social Security #: _____

Bluegrass Center for Autism admits children of any race, color, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to children at the center. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its policies, admissions policies, and other center-administered programs.

Parent/Guardian Information

(adult(s) with whom the child lives)

Parent/Guardian Name: _____

Relationship to child: _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Home Phone:_____Cell Phone:_____Work Phone: _____

Email Address: _____

Employer of Parent/Guardian: _____

Additional Parent/Guardian Name: _____

Relationship to child: _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Home Phone:_____Cell Phone:_____Work Phone: _____

Email Address: _____

Employer of Parent/Guardian: _____

PLEASE NOTE: In order for your child's experience at Bluegrass Center for Autism to be successful, we require each adult family member to attend team conferences, and parent workshops to ensure effective reinforcement may occur at home.

Family Information

Family Members/Siblings

Name:_____Age:_____Relationship to child: _____

Name:_____Age:_____Relationship to child: _____

Name:_____Age:_____Relationship to child: _____

Name:_____Age:_____Relationship to child: _____

Name:_____Age:_____Relationship to child: _____

Is the child you are enrolling into BCA adopted? Yes No If "Yes", at what age? _____

Please complete the information below for "Non-Custodial Adult(s)" (grandparents, stepparents, etc.) who have a caretaking role in the child's life.

Name:_____Relationship to child: _____

Home Address: _____

(Street) (City) (State) (Zip Code)

Home Phone:_____Cell Phone:_____Work Phone: _____

Email Address: _____

Employer: _____

Name:_____Relationship to child: _____

Home Address: _____

(Street) (City) (State) (Zip Code)

Home Phone:_____Cell Phone:_____Work Phone: _____

Email Address: _____

Employer: _____

Medical Information

Please complete medical information for all that apply

Child's Primary Care Physician

Name:_____Phone Number: _____

Address: _____

(Street) (City) (State) (Zip Code)

Child's Specialty Care Physician

Name:_____Phone Number: _____

Specialty:_____

Address: _____

(Street) (City) (State) (Zip Code)

Child's Psychologist/Psychiatrist

Name:_____Phone Number: _____

Specialty:_____

Address: _____

(Street) (City) (State) (Zip Code)

Child's Dentist

Name:_____Phone Number: _____

Address: _____

(Street) (City) (State) (Zip Code)

Child's Ophthalmologist

Name:_____Phone Number: _____

Address: _____

(Street) (City) (State) (Zip Code)

Medical Information (continued)

Please check all that apply for your child enrolling in BCA

___Allergies:
- ___Food: _____
- ___Insects: _____
- ___Drugs: _____
- ___Latex
- ___Seasonal: _____
- ___Other: _____

___Anxiety Disorder
___Asthma or Breathing Conditions
___Asperger's Syndrome
___Attention Deficit Disorder (ADD)
___Attention Deficit Hyperactivity Disorder (ADHD)
___Autism Spectrum Disorder (ASD)
___Bladder Conditions
___Bowel Conditions
___Cerebral Palsy
___Cystic Fibrosis
___Dental Conditions
___Diabetes
___Down Syndrome
___Head/Spinal Injuries
___Deaf or Hearing Impaired
___Heart Conditions
___Muscle Conditions
___Seizures
___Speech Delays/Conditions
___Visually Impaired/Blindness
___Other: _____
___Other: _____
___Other: _____

Date of last eye exam:_____ Date of last hearing test: _____

Please describe any other important medical/health related information about your child:

_____

_____

_____

Please list all your child's medications, prescriptions, supplements (including over-the-counter medication) below. Use extra page for additional medications, prescriptions, and supplements.

Medication	Dosage	Times per day	Condition	Physician

Please Note: Please make BCA staff aware of any adjustments/changes that are made to your child's medications.

Medical Information (continued)

In an emergency, do you give Bluegrass Center for Autism's staff permission to send your child (properly supervised) to an alternative hospital or physician, if you and/or your physician(s) cannot be reached? (circle one) Yes/No

As a parent/guardian, I authorize treatment of_____by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature:_____Date: _____

Documentation of your child's previous evaluations are needed. Specifically, but not limited to:

___Educational Evaluations/Plans

___Psychological Evaluations

___Speech and Language Evaluations/Plans

___Occupational Therapy Evaluations/Plans

Medical Information (continued)

Does your child have an Autism Spectrum Disorder (ASD) diagnosis? (circle one) Yes No

Who gave your child his/her ASD diagnosis?

Physician's Name: _____

Agency: _____

Date of ASD Diagnosis: _____ Child's Age when diagnosed with ASD: _____

What prompted you to seek an evaluation for your ASD diagnosis? _____

Please attach a copy of the original diagnostic evaluation and any additional diagnostic evaluation/treatment summary since that date.

_____

_____

Please complete only if your child has received services in any of the following areas:

Speech and Language

Therapist's Name: _____

Agency: _____ When was your child last assessed? _____

What are the goals for this intervention? _____

_____

Occupational Therapy

Therapist's Name: _____

Agency: _____ When was your child last assessed? _____

What are the goals for this intervention? _____

_____

Physical Therapy

Therapist's Name: _____

Agency: _____ When was your child last assessed? _____

What are the goals for this intervention? _____

_____

Applied Behavior Analysis (ABA) Therapy

Therapist's Name: _____

Agency:_____When was your child last assessed? _____

What are the goals for this intervention? _____

_____

Medical Information (continued)

Psychology or Psychiatric Services/Therapy

Therapist's Name: _____

Agency:_____When was your child last assessed? _____

What are the goals for this intervention? _____

_____

Does your child have a diagnosis of Epilepsy, or Seizure Disorder? (circle one) Yes No

If yes, please explain the frequency of seizures: _____

_____

Emergency Information

Child's Name: _____

Parent/Guardian names: _____

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

Additional Cell Phone: _____ Work Phone: _____

Email address: _____ Email address: _____

In the event of an emergency, and the parents/guardians listed above cannot be reached, list the name, phone number and email address of individuals Bluegrass Center should contact *(list should be adults over the age of 18):*

1. Name: _____ Relationship to child: _____

Phone: _____ Email address: _____

2. Name: _____ Relationship to child: _____

Phone: _____ Email address: _____

3. Name: _____ Relationship to child: _____

Phone: _____ Email address: _____

4. Name: _____ Relationship to child: _____

Phone: _____ Email address: _____

As a parent/guardian, I authorize treatment of _____ by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only of reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature: _____ *Date:* _____

Form MIR

Bluegrass Center for Autism

Medical Information Release Form

I, (please print)_____, Parent/Guardian of _____, a child attending Bluegrass Center for Autism, authorize the transmission of information regarding my child between Bluegrass Center for Autism representatives and my child's physician(s). I understand that all information regarding my child's physical, developmental, and emotional health will be kept confidential.

The following is a list of physicians who may be contacted by Bluegrass Center for Autism representatives on behalf of my child:

Primary Care Physician (Pediatrician):_____Phone:_____

Neurologist (if applicable):_____Phone:_____

Psychiatrist (if applicable):_____Phone:_____

Behavior Analyst (Home):_____Phone:_____

Outside Therapist:_____Phone:_____

Other:_____Phone:_____

Other:_____Phone: _____

Parent/Guardian Signature:_____Date: _____

PLEASE COMPLETE THE HIPAA PRIVACY AUTHORIZATION FORM (next page) FOR EACH PROVIDER LISTED ABOVE

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1) Authorization

I authorize (healthcare provider) to use and disclose the protected health information described below to Bluegrass Center for Autism.

2) Effective Period

This authorization for release of information covers the period of healthcare from:

a) ☐ _____ to _____

- - OR - -

b) ☐ all past, present, and future periods

3) Extent of Authorization

☐ a) I authorize the release of the complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) for

(Client name) _____ (Date of birth) _____

- OR - -

☐b) □ I authorize the release of the complete health record for (Client name) _____

(Date of birth) _____ with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse and treatment

☐Other (please specify):_____

4) This health information may be used by the entity I authorize to receive this information for medical/mental health treatment or consultation, billing or claims payment, or other purposes as I may direct.

5)This authorization shall be in force and effect until

_____ / _____(date or event), at which time this authorization expires.

6) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7) I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8) I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of parent or guardian:_____

Date: _____

Relationship to client:_____

Bluegrass Center for Autism

Medication Distribution Release Form

(Prescriptions Only)

I, (please print)_____, Parent/Guardian of _____, a child attending Bluegrass Center for Autism, authorize Bluegrass Center for Autism employees to administer the following medication(s) in the following dosage to my child. I release Bluegrass Center for Autism from all liability for administering the stated medication in the stated dosage.

- *All medication must be brought to Bluegrass Center for Autism in its original container, with prescription label on the original container.*
- *This Release does NOT need to be completed for "over-the-counter" medicine and/or supplements, however Bluegrass Center for Autism must be aware of any "over-the-counter" medicine and/or supplements that are given to your child at home.*

Medication (please write the entire name): _____

Dosage:_____Frequency (how many times per day): _____

Instruction for administering (include time of day, special instructions, etc.): _____

_____

Parent/Guardian Signature:_____Date:_____

Physician's Signature:_____Date:_____

Physician's Phone:_____ Physician's Agency/Group: _____

Please note: Please print this page off for each prescription medication your child is currently taking.

Form E-1

Allergy Emergency Plan

(only complete if applicable)

Child's Name:_____ Age: _____

Parent/Guardian Name:_____ Phone: _____

As a parent/guardian, I authorize treatment of_____by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature:_____Date: _____

Type of Allergy: _____

Identify the triggers which begin allergic reaction: _____

_____

Symptoms of allergic reaction: _____

_____

Instructions if allergic reaction occurs: _____

_____

Type of Allergy: _____

Identify the triggers which begin allergic reaction: _____

_____

Symptoms of allergic reaction: _____

_____

Instructions if allergic reaction occurs: _____

_____

Form E-2

Seizure Emergency Plan

(only complete if applicable)

Child's Name:_____Age: _____

Parent/Guardian Name:_____Phone: _____

As a parent/guardian, I authorize treatment of_____by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature:_____Date: _____

Type of seizure: _____

Identify the triggers which begin seizures: _____

_____

Symptoms of seizures: _____

_____

Instructions if seizure occurs: _____

_____

Type of seizure: _____

Identify the triggers which begin seizures: _____

_____

Symptoms of seizures: _____

_____

Instructions if seizure occurs: _____

_____

Form E-3

Asthma Emergency Plan

(only complete if applicable)

Child's Name:_____ Age: _____

Parent/Guardian Name:_____ Phone: _____

As a parent/guardian, I authorize treatment of_____by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature:_____Date: _____

Identify the triggers for an asthma attack: _____

_____

Symptoms of an asthma attack: _____

_____

Instructions if an asthma attack occurs: _____

_____

Identify the triggers for an asthma attack: _____

_____

Symptoms of an asthma attack: _____

_____

Instructions if an asthma attack occurs: _____

_____

Form E-4

Diabetic Emergency Plan

(only complete if applicable)

Child's Name:_____ Age:_____

Parent/Guardian Name:_____ Phone: _____

As a parent/guardian, I authorize treatment of_____by a qualified, licensed medical physician in event of a medical emergency, which may endanger his/her life, cause physical disability or undue discomfort if delayed. This consent is granted only if reasonable efforts have been made to contact me. If continued efforts to contact me are unsuccessful, or should expediency make it impractical or dangerous to the health of my child, I authorize a physician to take such action as he/she deems necessary.

Parent/Guardian Signature:_____Date:_____

Identify the triggers for a diabetic emergency: _____

_____

Symptoms of a diabetic emergency: _____

_____

Instructions if a diabetic emergency attack occurs: _____

_____

Identify the triggers for a diabetic emergency: _____

_____

Symptoms of a diabetic emergency: _____

_____

Instructions if a diabetic emergency attack occurs: _____

_____

Bluegrass Center for Autism

Payment Policy

Financial obligations are crucial to the successful operation of Bluegrass Center for Autism. Bluegrass Center for Autism's administration and Board of Directors set and approve our Payment Policy and fees annually. All parents/guardians must sign this agreement in order for their child to attend Bluegrass Center for Autism and agree to make payments as selected below.

Deposit: An initial $500.00 *non-refundable* deposit must be made during the registration process. Deposits will be applied towards the child's annual fees.

Payment Option:

1. ____ Automatic ACH withdrawal from your checking/savings account. (suggested method)
   If you select this option, please complete the provided ACH form.

2. ____ Personal Check/Money Order. (Cash is not accepted)

Payment Frequency: Please select payment frequency option: *Uninsured Clients ONLY*

1. ____ Full payment due prior to the beginning of Regular Session.

2. ____ Quarterly payments due in August, November, February, and May.

3. ____ Bi-Annual payments due in August and January of Regular Session.

4. ____ Monthly payments due on the 20th of each month.

5. ____ Bi-Monthly payments due on the 5th and 20th of each month.

Bluegrass Center for Autism

Payment Policy (continued)

Payment Policies:

1. Failure to submit payments as agreed above will result in your child's dismissal from Bluegrass Center for Autism, and all collection options will be sought if necessary. For default payments please see the additional policy below.

2. A $50.00 charge will be applied to any account whose ACH payment and/or check does not clear or is declined.

3. Bluegrass Center for Autism does NOT accept cash as a form of payment.

4. Bluegrass Center for Autism payments for services are non-refundable.

5. Families who utilize "Insurance Billing" are responsible for all costs not covered and/or paid by their insurance company, including copays and coinsurance.

I have read, understand, and agree to the conditions outlined above. I understand and acknowledge that by signing below, I agree to submit payments as outlined above for all payments due to Bluegrass Center for Autism.

Name of Child

Parent Signature Date

Parent Signature (if applicable) Date

Bluegrass Center for Autism

Medicaid Patient Cap Policy

As of May 1, 2021, Bluegrass Center for Autism ("BCA") will adopt the following policy as it relates to accepting Kentucky Medicaid as a primary or secondary source of coverage for provided services:

BCA will continue to accept Kentucky Medicaid insurance for covered services. However, BCA will cap the number of patients utilizing the Medicaid programs at fifty percent of its overall patient capacity. In implementing this policy, BCA will maintain a specific waitlist for Medicaid patients after it reaches capacity. Waitlisted patients will be contacted on a first-come, first-served basis as patient capacity allows BCA to accept new Medicaid patients. BCA will continue to monitor utilizations and will adjust the fifty percent Medicaid Cap, as necessary.

Bluegrass Center for Autism
Proposed
Payment/Collection Policy

Invoices not paid within 30 days will begin to accrue $30 flat fee per month, until the invoice is paid in full, or a payment plan has been agreed upon.

After 60 days of sending an invoice to a Bluegrass Center for Autism client, our Systems and Billing Director will contact any client who has not made full payment of the invoice, or a payment plan is not created and/or followed. The Systems and Billing Director will request full payment of the invoice or a payment plan initiated and implemented.

Within 30 additional days (90 total days from initial invoice sent), if full payment is not made, or a payment plan is not created and/or followed, the Executive Director will contact the family to request full payment of the invoice or a payment plan to be initiated and implemented. If client does not respond or no agreement is made, then services may be suspended or terminated, and the account will be turned over to an outside collection agency

Billing Due	Payment Terms
Within 30 days of invoice	• If not paid in full within 30 days, late charges of $30 per month will apply.
60 days overdue	• $30 late fee applies, and Systems and Billing Director will contact clients for resolution.
90 days overdue	• Executive Director will contact client for resolution. If agreement is not made, services may be suspended or terminated, and bills turned over to a collection agency.

BCA Payment Plan Policy for Past Due Accounts

1. Payment Plans are allowable for past due accounts and current balances over $1000.00.

2. All payment plans must be paid through ACH, unless otherwise approved by the BCA Finance Committee.

3. Payment Plans may not extend more than 6 mos. without approval from the BCA Finance Committee.

4. Clients must stay current on their regular billing.

5. Failure to communicate with Billing Director or Executive Director and missed payment will result in immediate suspension of services.

6. Payment Plans may be created by contacting Jennifer Wilt at jwilt@bcaky.org

Authorization Signature & Financial Information

Parent/Guardian signature:_____

Date:_____

Email for financial communication:_____

Parent/Guardian printed name:_____

Additional email for financial communication:_____

Mailing Address for financial communication:_____

Phone number for financial communication:_____

AUTHORIZATION SIGNATURE & FINANCIAL INFORMATION

Parent/Guardian signature line Date

Email for financial communication

Parent/Guardian printed name

Additional email for financial communication

Mailing Address for financial communication

Phone number for financial communication

Address Line 2

Name on Credit Card

Credit Card Number

Expiration Date

Security Code (3-digit code)
(AMEX 4-digit code)

Billing Zip Code

Credit Card Type (all major credit card accepted, i.e., Visa, Mastercard, Discover, American Express)

AUTHORIZATION AND RELEASE

As a courtesy, Bluegrass Center for Autism ("BCA") will file insurance claims on behalf of qualified participants in our program. However, the client's Parent or legal Guardian is ultimately responsible for all charges. By completing this Authorization and Release, you acknowledge your consent to provide services and your financial responsibility for those services. Please refer to the Bluegrass Center for Autism – Health Insurance Coverage and Payment Policy for more details regarding payment policies.

CONSENT FOR SERVICE PROVISION TO A MINOR CHILD or INDIVIDUAL IN LEGAL GUARDIANSHIP

Your signature indicates that you are granting permission for your minor child or individual in your legal guardianship_____, Date of Birth _____, to receive services at Bluegrass Center for Autism as they deem advisable from this date. Your signature indicates that you are the legal parent or guardian of this minor child/individual and are legally able to authorize treatment for this child/individual. You may be asked to present proof of guardianship by the staff of the Bluegrass Center for Autism in order to proceed with services. This consent will be valid for one (1) year from this date or until consent is revoked in writing. Your signature certifies that you have been made aware of the role and services offered by Bluegrass Center for Autism and consent to care by such providers. Your signature indicates that you understand these services are voluntary and that you have the right to refuse these services.

Name: _____

Signature:_____Date:_____

Relationship to Minor Child/Individual in Legal Guardianship: _____

AUTHORIZATION TO FILE CLAIMS

Please choose Option A or Option B by placing an X and then signing below:

_____Option A: I do not have commercial insurance coverage for services provided by Bluegrass Center for Autism and will be paying for all services out-of-pocket at the current prompt pay adjusted rate. I do not authorize Bluegrass Center for Autism to file claims for services to my insurance plan.

Signature of Parent/Guardian:_____Date: _____

_____Option B: I hereby authorize Bluegrass Center for Autism to file claims for services to my insurance plan, Medicaid, Medicare, and/or any other government agency for reimbursement. I request that Bluegrass Center for Autism furnish any and all information they may require from my record in order to process such a claim.

Signature of Policyholder:_____Date:_____
Printed Name of Policyholder: _____
SSN of Policyholder:_____ Policyholder Date of Birth:_____
Insurance Company:_____Member ID:_____Group ID:_____
Plan Start Date:_____Plan End Date:_____E-mail: _____

ASSIGNMENT OF BENEFITS (if choosing Option B):

I hereby authorize payment of benefits from my insurance plan, Medicaid, Medicare, and/or any other government or private plan to be paid directly to Bluegrass Center for Autism, which will be credited to my account. I also understand that I am financially responsible for any amounts not covered by my insurance company including copayments, coinsurance amounts, deductibles, and any amount over theusual reasonable and customary guidelines.

Signature:_____ Date:_____
Parent/Guardian

NOTICE OF PRIVACY PRACTICE RECEIPT

I have received a copy of and/or had the opportunity to request a copy of Bluegrass Center for Autism "Notice of Privacy Practice".

Signature:_____ Date:_____
Parent/Guardian

Bluegrass Center for Autism – Health Insurance Coverage and Payment Policy

Bluegrass Center for Autism provides Applied Behavior Analysis (ABA) services. Thus, many health insurance plans will help you pay for the services we provide. However, health insurance does not allow Bluegrass Center for Autism or its employees to "signoff" on the work performed by others. Doing so is considered "fraud." Only the services provided by Bluegrass Center for Autism will be billed under our name.

Health insurance is written by many different companies, and many of those companies write individually tailored plans for specific employers. Thus, BCA cannot tell you what your plan covers. Please read your plan's coverage booklet, call your Human Resources department, or your insurer's office to find out what you need to know. If your health insurance pays a portion of our fees for services, BCA will provide reasonable assistance with your insurance claims. However, please keep these things in mind:

1) Bluegrass Center for Autism had no role in deciding what your insurance covers. Your employer decided which, if any, of our services will be covered and how much you (and we) will be paid. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, coinsurance, out-of-pocket maximums, and so forth. Your insurance contract is between you and your company; it is not between BCA and the insurance company.
2) You, not your insurance company or any other person or company, are responsible for paying the fees we agree upon. In addition, you are responsible for any copayments, coinsurance, deductibles, and any claims declined by the insurance carrier. In the event that your insurance carrier has not remitted payment to us within 45 days of the date of claim receipt, you acknowledge that the entire account balance becomes your responsibility.
3) As a contracted provider (in-network) with Anthem KY, Humana and CareSource Marketplace, Bluegrass Center for Autism will file insurance claims for our services with those entities after authorization for treatment is obtained.
4) BCA can only bill for services that are authorized by insurance. You are responsible for paying prompt pay adjusted fees until an authorization for services is obtained from your insurance company. If an authorization for services is received for dates that you have previously paid prompt pay adjusted fees, BCA will file insurance claims for those dates as long as they are within a reasonable timeframe and credit your account with any payments you have made above the amount of your "patient responsibility" according to the Electronic Remittance Advice (ERA) from your insurance provider.
5) Any required Pre-Authorization or Pre-Certification for insurance is your responsibility. BCA will assist you with the process, but it is your responsibility to obtain necessary authorizations or referrals required by your insurance carrier prior to the commencement of services.

6) Insurance companies do not always authorize the number of visits, hours, or days of service provided by BCA. In those instances, you will be responsible for the prompt pay adjusted fees for any additional services not authorized by insurance.
7) Insurance companies do not pay for missed appointments or days; these fees remain your responsibility. Anytime BCA is in operation and your insurance cannot be billed for services by BCA, you are ultimately responsible for paying the prompt pay adjusted fees. BCA allows 30.5 hours (one week) of missed time each calendar year (prorated based on start date) before you will be charged No Show Fees.
8) BCA will attempt to file claims for out-of-network insurance claims at your timely request and our discretion. However, if we are unable to file claims electronically or have rejections of these claims, you will be responsible for prompt-pay adjusted fees for BCA services.
9) Failure to make prompt payment for services rendered by BCA can result in placement of your account with a collection agency and the suspension of services. All expenses incurred through these collection efforts will be billed to the parent/guardian.

I/We have read and understand the Bluegrass Center for Autism – Health Insurance Coverage and Payment Policy. I/We understand that claims for insurance will not be filed by Bluegrass Center for Autism until acknowledgement of this policy is signed and returned to BCA along with the completed Authorization and Release form. This policy will be reviewed at least annually and updated as needed.

_____ _____

Signature of parent(s) or guardian(s) Date

_____ _____

Printed name of parent(s) or guardian(s) Printed name of client

Form ACH

Bluegrass Center for Autism

ACH Form

(only complete if applicable)

Payer's Contact Information

Child's Name: _____

Payer's Name: _____

Secondary Contact: _____

Payer's Address: _____
Street *City* *State* *Zip*

Payer's Phone: _____

Payer's Email Address: _____

ACH Banking Information

Select one: ___: Checking Account ___: Savings Account

Please attach a "VOIDED" check to this form –or- complete the information below:

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

I hereby authorize Bluegrass Center for Autism to initiate debit entries to my account indicated above (or attached) and my bank, to debt the same such amount. This authority is to retain in full force and effect until Bluegrass Center for Autism and my bank have received written notification from me of its termination. I hereby agree to any and all information and agreements noted above.

*Payer's Signature:*_____ *Date:* _____

Bluegrass Center for Autism

Photo/Media Release Form

I, the parent/legal guardian grant my permission for Bluegrass Center for Autism to exhibit photographs, audio, video and/or other likeness of the above-named child in print and/or electronically for Bluegrass Center for Autism purposes only.

I agree that Bluegrass Center for Autism may use such photographs, audio, or video of my child for any lawful purpose, including BCA sanctioned purposes such as publications, newspaper articles, professional development, marketing materials, BCA website, BCA social media, hallway bulletin boards, and other such material.

BCA does not permit clinical employees to share or create media with identifying information on social media. Client participation in marketing requests is voluntary and will not affect client treatment. Any media interviews are not held during regularly scheduled treatment hours. Any client story sharing is handled within BCA's marketing department and is separate from the clinical department. BCA ensures that all audio and visual images are appropriate and used to highlight BCA activities and not exploitive of clients. Parents/Guardians have the opportunity to relinquish consent upon request. This photo release is renewed annually.

I have read and understand the above, and give my consent as marked below:

_____I/We hereby give permission to Bluegrass Center for Autism to use my child's image for the purposes stated above.

_____I/We hereby give permission to Bluegrass Center for Autism to use my child's image only within the confines of BCA. (not including social media/website/or any other print or audio media)

_____I/We hereby DO NOT give permission to Bluegrass Center for Autism to use my child's image in any form or capacity.

Printed name of parent/guardian: _____

Signature of parent/guardian: _____

Date: _____

Bluegrass Center for Autism

Functional Behavior Assessment Consent Form

I,_____, parent/guardian of_____,
give my informed consent to the Bluegrass Center for Autism to conduct a Functional Behavior Assessment (FBA) for my child. The purpose of this assessment is to identify a hypothesized function or functions for behavior(s) that may be targeted for reduction. Knowledge of the function(s) of behavior is essential for successful reduction of the behavior and must be known prior to developing a Behavior Plan. This assessment may include the following:

- Indirect assessment
    - Informal and/or structured interviews of parents and/or staff
    - Informal and/or structured interviews of other therapists
- Direct observation
    - Collection of data on the antecedents and consequences to behaviors

As a parent/guardian, you may request the results of this assessment at any point. In addition, results will be discussed with you when your assigned Behavior Analyst reviews your child's Behavior Plan with you.

_____ _____

Parent/Guardian Date

Bluegrass Center for Autism

Safe Crisis Management Release

I_____parent/guardian to_____, a learner and or prospective learner at Bluegrass Center for Autism, give permission for the trained staff at Bluegrass Center for Autism to implement Safe Crisis Management (SCM) procedures with my child, only if necessary. I understand that these procedures will only be used as a last resort and after all other procedures have been implemented but deemed unsuccessful by our Program Director or Program Coordinator. I understand that there is a risk for possible injury to my child but that all precautions will be taken to prevent injury. I realize that these procedures are utilized to keep my child, other children, and the staff at Bluegrass Center for Autism safe at all times. A Program Director will notify me that day and provide me with written documents detailing the event, if any SCM restraints are used.

I am aware that staff at Bluegrass Center for Autism have been trained and certified by a certified SCM trainer through JKM Training, Inc.

Parent Signature Date