Dear Parents,

Thank you for your interest in our center-based Autism services at Autism Systems. Our mission is to positively impact the life of each child with the diagnoses of Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder-Not Otherwise Specified, and other disabilities, by providing an environment that enables the child to reach their greatest potential.

Treatment services are aimed at developing and improving your child's communications, interaction with others, expressing emotions and coping strategies. The Assessment of Basic Language and Learning Skills-Revised (ABLLS-R), Verbal Behavior Milestones Assessment & Placement Program (VB-MAPP), and Early Echoic Skills Assessment (EESA) curriculums enable our staff to assess and assign measurable objectives in developing the Individual Treatment Plan for the child. In addition to these curriculums, we use a variety of supplemental programs to meet each child's individual needs. Through our rigorous data collection, we actively track your child's progress through our program.

To ensure that your child receives the most fitting treatment, the initial evaluation of your child is critical. This should include a comprehensive assessment of your child's physical, developmental, and mental health needs as well as a copy of your child's Education Plan. This evaluation guides the direction of treatment and ensures that the treatment goals are appropriate for your child's optimal growth and development. This is important baseline information for you to have so that you can have an accurate understanding of your child's current abilities as well as a basis for comparison to measure progress in treatment over time. These evaluations are also a requirement of most insurance companies.

The following areas of your child's overall health will need to be assessed **prior** to beginning treatment at Autism Systems. These evaluations do not have to be completed with one particular health care provider but must meet the outlined requirements. All evaluations must be completed before the anticipated start date. Once Autism Systems receives records of each of these evaluations and we receive funding approval, your child's treatment start date can be determined.

Initial	Evaluations/Assessments
	Medical Evaluation – this is an examination by a licensed physician. It is important that your child's physical health be assessed, in addition to any family history or other medical issues. To comply with our state Child Care licensure, a Health Assessment form is included in this enrollment packet which will need to be completed by the licensed physician.
	Autism-specific Diagnostic Assessment – this evaluation can be completed within the Psychological Evaluation. It needs to include the diagnosis of Autism from the DSM-IV with axis clarification and diagnosis code.
	Copy of Education Plan – most recent Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)
	Immunization Record- The immunization record document included in this enrollment packet needs to be documented, completed and signed by you. In addition the record can be faxed to us by your licensed physician's office to 920-739-3709 or some providers have on-line access where this document can be printed. If your child is **NOT** vaccinated, please indicate this under the appropriate section of the immunization document that you complete.
	Alternate Transportation – If your child will be arriving or departing Autism Systems by alternate transportation such as a cab or bus this document will need to be completed by the parent. If your child will **NOT** be using alternate transportation, you can discard this document from the Enrollment Packet.
	Child Enrollment Form- Due to our state licensing for child care regulation, this child record document covers some information that is a duplicate of the information needed from this enrollment packet; however, due to treatment record requirements, both will need to be completed in its entirety.

It may be helpful to bring this letter to your chosen providers to explain the particular kind of assessments that your insurance provider requires before treatment can begin. If you have questions regarding the enrollment process or need referrals please contact Jessica Meyer, Director, for assistance.

NOTE: If your child already has an audiology or speech assessment completed, please provide those to Autism Systems as well.

Emergency Plan

Date Filled Out __/___/___

Important! Use only BLUE Ink when filling out this form!

_____ _____ _____

Child's Name | Date of Birth | Gender

_____

Address | City, State, Zip

_____

(Mother/Guardian) | Address (if different) | Phone #1 and description ("call first" "only call morning, etc.")

_____

(Father/Guardian) | Address (if different) | Phone #1 and description ("call first" "only call morning, etc.")

_____

Additional phone numbers and email

_____ _____ _____

Emergency Contact #1 | Relationship | Phone Number(s)

_____ _____ _____

Emergency Contact #2 | Relationship | Phone Number (s)

_____ _____ _____

Child's Physician | Clinic Name and Address | Clinic Phone Number

_____ _____ _____

Child's Dentist | Practice Name and Address | Practice Phone Number

_____ ___Y____N_____ _____

Transport to which hospital? | City | Registered There? | Hospital Phone Number

Allergies **Type (Food, Medicine, Other)**	**Description**	**Remarks**
Medications: Name	**Used For**	**Administered by** Autism Systems**?**
		YES ***NO***
		YES ***NO***
		YES ***NO***
		YES ***NO***

Medications and Allergies continued……...

Emergency Action Plan for Seizures & Allergies

Child has a seizure history:

Emergency Plan: 911 will be called if

- Seizure lasts longer than____ minutes
- Your child is having difficulty breathing
- Vomitus is aspirated
- A significant injury occurs during the seizure
- Status epilepticus occurs (continuous seizure)

Describe your child's typical seizure:

Please list step-by-step instructions for Autism Systems **staff if your child has a seizure while at the center:**

Call parent when:

Call physician when:

The following people are authorized to pick up your child

Name	Relation to child	Phone number

The following people are restricted from contact with your child

Name	Relation to child

I give permission to Autism Systems to take whatever emergency (e.g. first aid, disaster evacuation, etc) measures are judged necessary for the care and protection of my child while at Autism Systems: YES NO

I give permission for my child to be transported to the appropriate medical facility by the local emergency unit for treatment: YES NO

I understand that in some medical situations, the staff will need to contact local emergency resources before the parent/guardian, child's physician and/or another adult acting on the parent/guardian's behalf.

Parent/Guardian Signature: _____ Date:_____

Client Name:

AUTHORIZATION FOR TREATMENT:
By signing this form, I consent to and authorize Autism Systems to Evaluate and provide treatment to my child, the above named patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR MEDICAL CARE:
I authorize release of pertinent medical information to other treating healthcare providers, for purposes of my child's treatments at Autism Systems and for business operations:

Initial: Yes No

CLIENT'S RIGHT TO PRIVACY:
I acknowledge that I have been given a copy of the Autism Systems Privacy Notice (HIPAA).

Initial: Yes No

CLIENT'S BILL OF RIGHTS:
I acknowledge that I have been given a copy of the Autism Systems Client's Bill of Rights.

Initial: Yes No

AUTHORIZATION FOR COMMUNICATION VIA EMAIL:
I authorize Autism Systems and it's authorized personnel to use email as needed to communicate with me and internally for purposes of my child's treatments at Autism Systems and for business operations.

Initial: Yes No

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES:
I authorize release of pertinent medical information to third party payers/insurance companies to determine payments related to treatment received.

Initial: Yes No *If NO, you are assuming all financial responsibility for your services.

ASSIGNMENT OF BENEFITS:
I authorize payment of benefits be made directly to Autism Systems for services provided to my child, the above named patient, by Autism Systems. I understand and agree that I am financially responsible to Autism Systems for charges not covered by insurance. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

Initial: Yes No *If NO, you are assuming all financial responsibility for your services.

The above information is warranted to be true. I agree to pay all bills with 10 days after receiving an invoice or as otherwise expressly agreed in writing. I hereby authorize Autism Systems to investigate any information obtained from me pertaining to my financial responsibility.

Parent/Legal Guardian's printed name	**Signature**	**Date**

REGISTRATION FORM

Please print legibly in Black Ink

Client Information

Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Sex: M F Age:_____ Date of Birth:_____ Diagnosis:_____

Primary Insurance

Name of Primary Insurance Company:_____

Contract#:_____ Group# :_____ ID#:_____

Insurance Policy Holder:_____ Relationship to Client:_____

Date of Birth:_____ Employed by:_____ Occupation:_____

Business Address:_____ Business Phone:_____

Secondary Insurance

Name of Primary Insurance Company:_____

Contract#:_____ Group# :_____ ID#:_____

Insurance Policy Holder:_____ Relationship to Client:_____

Date of Birth:_____ Employed by:_____ Occupation:_____

Business Address:_____ Business Phone:_____

Medical Assistance

(Write "N/A" if your child does not have Medical Assistance)

Your child's MA number:_____

Assignment & Release

I, the undersigned, have insurance with:_____

Name of Insurance Company

and assign directly to Autism Systems all medical benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by insurance. I hereby authorize Autism Systems to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Parent/Guardian/Responsible Party Date

Financial Agreement

This financial agreement sets Autism Systems expectations regarding payment. Autism Systems believes that financial arrangements should be discussed and understood prior to the onset of services and before any problems or concerns develop.

Prior to receiving services, Autism Systems will work with you to ensure that the funding source you are planning to use will pay for services. It is the parents' responsibility to monitor the funding source they are using and to immediately notify Autism Systems of any changes to insurance or other coverage's.

It also needs to be understood that if you are using the state's Children's Long Term Support Waivers (CLTS), this is a payer of last resort. Therefore, even if your child has primary insurance that will not cover the service, Autism Systems needs to be aware that the primary insurance exists as each year a denial letter/denied EOB will need to be placed in your child's file both at Autism Systems and with your County's agency to support why the CLTS Waiver is being used to fund your child's therapy.

When discussing payment for services with insurance companies it is important that the insurance company clearly understands the type of services Autism Systems provides. Autism Systems provides Intensive Behavioral Therapy (ABA therapy) in a center-based program delivered by unlicensed mental health practitioners under the direction of a licensed Behavior Analyst.

It is essential that Autism Systems is involved in the prior authorization process. To do this, it is necessary for you to provide our Center Director with the required information that enables us to bill your insurance company. A copy of your insurance cards will be requested as well as the name and birthdate of the primary member. In some circumstances even participating insurance plans require you to pay a balance not covered. It is your responsibility to know what limitations, exclusions, deductibles, co-insurance or co-pays your plan has. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract and our financial relationship is with you, not your insurance company.

Private Pay
Autism Systems will enter into a Private Pay Agreement with private parties. Autism Systems sends invoices on a bi-weekly or monthly basis as arranged prior to the start of services and expects that payment will be received within 3 business days after the invoice is received. Autism Systems offers an initial package rate for families in order for Autism Systems to appropriately conduct assessments, develop a treatment plan and prepare for a child's treatment.

Payment in Full
In some cases a funding source may pay for only a portion of the charges. Unless specifically contracted; co-pays, co-insurance, discounted charges and deductibles are the responsibility of the insured. Autism Systems will prepare a statement with outstanding charges due on a monthly basis and payment is due from this statement 3 business days upon receipt of the statement. Insurance companies often discount rates to a "usual and customary" price. Unless contracted, Autism Systems does not accept discounted rates.

Autism Systems accepts checks, money orders, ACH and Credit/Debit Cards (Visa and MasterCard) for payments. Returned checks will incur an additional fee of $25.00 that will be added to your bill. Prior to your child's first day at Autism Systems, our Center Director will contact you to complete and authorize the necessary paperwork for the payment of out of pocket amounts and services not covered by your insurance plans. Payments for out of pocket expenses and services must be made prior to your child's first day of therapy at Autism Systems.

Payment Plans are available to clients who are unable to pay their bill on time. Please contact our Office Manager- Danette Locke to arrange a payment plan.

Delinquent Accounts
An account is considered past due when payment is not received 30 days from the statement date. If other written arrangements have been agreed to, the arrangements need to follow the written agreement. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency. Legal costs incurred in collecting delinquent accounts will be the responsibility of the person responsible for the account.

If the insurance company does not pay your balance in full within 30 days, we will ask that you contact your insurance company to help facilitate the processing of this payment.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to contact us so we can assist you in the management of your account.

Secondary Insurance
Autism Systems will invoice a secondary insurance in the same manner as a primary insurance source. In all cases, Autism Systems will bill the primary insurance first and the secondary insurance once Autism Systems has obtained the Explanation of Benefits (EOB) from the primary insurance. This will occur for those that are using both primary insurance and CLTS Waivers.

Insurance Disputes
Despite everyone's best efforts, at times a dispute will occur over payment from an insurance company. It is our policy to assist you in obtaining payment from an insurance company. However, if the account is delinquent; Autism Systems will request payment from you as a private individual and reimburse you when and if the insurance company decides to pay for the services in dispute.

Missed and Late Therapy Appointments
We would appreciate the courtesy of a call if you are unable to keep an appointment. Please notify our office at least twenty four (24) hours prior to the appointment time. We reserve the right to charge a missed appointment fee for each appointment that is not canceled in a timely manner.

Chronic absenteeism and tardiness will have a negative effect on your child's therapeutic progress and may result in termination of services.

Divorce Decrees
Autism Systems will not enter into any disputes between parents who have separated or divorced. One parent must agree to be the person responsible for the child's account.

Interest and Late Charges
Autism Systems reserves the right to charge interest up to the amount allowed by law (currently 18%) for late payments.

Consequences for Non Payment
Autism Systems reserves the right to discharge your child from therapy or suspend therapy for unpaid services or accounts that are delinquent. If services are terminated or suspended; your child is placed on the waiting list and may begin services after the account is paid in full and payment for future services is established.

My signature indicates that I have received a copy of Autism Systems' Financial Agreement and I have read and understand that I am responsible for my child's account and agree to pay for services as indicated in this agreement.

_____ _____ _____

Parent/Guardian/Legal Representative Signature **Date** **Printed Name**

_____ _____ _____

Parent/Guardian/Legal Representative Signature **Date** **Printed Name**

PICTURE/VIDEO RELEASE

Client Name:_____ Date of Birth: _____

Autism Systems Autism Systems uses photographs and/or videos of children receiving services in our center based program for the purpose of instructions analysis, training, reporting, and selected marketing pieces for program awareness.

I have indicated below that photographs/digital images, video clips, and/or quoted remarks may be used as follows: (Circle all that you authorize)

Yes	**No**	Staff/ Client Photo Board
Yes	**No**	Pictures used internally for individual programming (such as PECS books, Visual Schedules, Social Stories, etc)
Yes	**No**	Video used to document programming
Yes	**No**	Scrapbooks
Yes	**No**	Printed publications or materials (such as magazines, newspapers, brochures and flyers)
Yes	**No**	Electronic publications or presentations (TV or other broadcast media)
Yes	**No**	Website (Autism Systems website, Facebook)

I agree that my child's name and identity ___ may be revealed **OR** ___ may not be revealed in descriptive text or commentary along with the image(s).

I agree that the media ___ may **OR** ___ may not contact my family to speak with my child regarding his/her involvement with Autism Systems.

I authorize the use of these materials (as indicated above) indefinitely without compensation to me. All negatives, positives, prints, digital reproductions and video or audio recordings shall be the property of Autism Systems.

_____ _____

Parent/Legal Guardian Signature Date

Occupational Therapy/Speech Therapy Interest Form

**** Autism Systems does not currently provide these service at the facility; however this document should still be completed so that it can be used to assess how many learner's will be using these services once providers are identified.**

Date: _____

Client Name:_____

Parent(s):_____

Phone Number:_____

Occupational Therapy

☐ Yes, I would like my child to receive Occupational Therapy services at Autism Systems

- ☐ Currently receiving services at:
- ☐ Previously received services at:
- ☐ Has not previously received Occupational Therapy

☐ No, I do not want to enroll my child in Occupational Therapy services at Autism Systems

- ☐ Currently receiving services at:
- ☐ Previously received services at:
- ☐ Has not previously received Occupational Therapy

Speech Therapy

☐ Yes, I would like my child to receive Speech Therapy services at Autism Systems

- ☐ Currently receiving services at:
- ☐ Previously received services at:
- ☐ Has not previously received Speech Therapy

☐ No, I do not want to enroll my child in Speech Therapy services at Autism Systems

- ☐ Currently receiving services at:
- ☐ Previously received services at:

☐ Has not previously received Speech Therapy

SUNSCREEN PERMISSION

Children are given the opportunity to go outside to play activities in the fenced in area or go on short walks. Children will be dressed appropriately for the weather. In cold weather, children will be required to wear hats, mittens, and boots if appropriate. In warmer weather, staff will apply sunscreen to clients going outdoors for more than 15 minutes. Children with a history of bolting may not be permitted to go on short walks due to safety concerns.

Name of Child: _____

○____ As the parent/guardian of the above mentioned child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer. Therefore, **I give permission** for the staff at Autism Systems to apply sunscreen (provided by Autism Systems).

○____ Autism Systems staff have permission to ONLY use the brand/type of sunscreen I have provided.
Note: If your child does not have his/her own sunscreen, he/she will not be allowed to go outside.

○____ My child does not need to wear sunscreen.

_____ _____
Parent/Guardian's Name Date

_____ _____
Parent/Guardian's Signature Date

Note: DO NOT RELY ON SUNSCREEN ALONE TO PROTECT CHILDREN FROM SKIN CANCER!
You may also send in hats and sunglasses to help protect your child.

Parent Handbook Acknowledgement Form

***** Please note that to help our Earth, parent handbooks are e-mailed to parents after an email has been provided to Autism Systems. Please return this document once you have received and read the e-mailed document.**

By signing the Parent Handbook Acknowledgement Form, you are indicating that you have read, understand and agree to follow the Policies and Procedures relating to parents. The Parent Handbook consists of a basic outline of Autism Systems Autism Therapy services and expectations. Please keep the handbook in a safe place to use it in the future for reference and information. There is also a copy of the year's most current parent handbook located in the front main entrance of Autism Systems for your viewing.

The Parent Handbook is subject to change without notice. Parents will receive notification of these changes.

Thank you,

Clinical Director

Child's Name: _____ Date of Birth: _____

My signature indicates that I have received a copy of the parent handbook. I understand that it is my responsibility to read, understand and follow the Policies and Procedures outlined in this handbook and any future revisions.

Parent Signature: _____ Date: _____

Client Bill of Rights (Parent Copy)

Autism Systems believes in treating children and their families with respect and dignity. We are also committed to abiding by the laws and public policies, which govern relationships between consumers and agencies providing

Autism Systems **acknowledges that the clients and their families have the following rights:**

- You and your child have the right to receive courteous treatment and appropriate care based on your needs.
- You have the right to know the qualifications/credentials of the staff.
- You have the right to receive information about your child's treatment in language you can understand. This includes being informed of the therapy program and the nature and purpose of the treatment as it relates to your child.
- You have the right to know the estimated length of the therapy, costs, goals and all the information related to the progress of your child.
- You have the right to make decisions about your treatment plan prior to and during the course of treatment.
- You have the right to refuse to provide information at any time. However, lack of information may affect our ability to help your child and reduce the possibility of receiving outside funding for the services provided.
- You have the right to refuse treatment or request alternate staffing.
- You have the right to review your child's internal therapy records; however, records Autism Systems may have received from outside sources cannot be released to you.
- You have the right to every consideration of privacy of information.
- You have the right to request the release of information to any person or organization you choose.
- You have the right to receive complete information about our services.
- You and your child have the right to receive services free from sexual harassment (both physical and verbal).
- You have the right to receive services and be free from any form of exploitation.
- You have the right to be informed of the policies and procedures of Autism Systems.
- You have the right to not be terminated from our program without explanation and/or notice.

- You have the right to express dissatisfaction or request a change in the treatment plan without restraint, interference, coercion, discrimination or reprisal.

- You have the right to not be discriminated against on the basis of race, religion, age, gender, ethnic origin, creed, sex, sexual orientation, arrest or conviction record, or status with regard to public assistance.

- You have the right to file a complaint or grievance.

Client Responsibilities

As a client of Autism Systems, you have responsibilities as well as rights.

- You are responsible to be clear and direct about your child and his/her disability or developmental delays. It is important for you to provide complete and accurate information about your child's medical history, medications and any other matters relating to your child.

- You are responsible to understand your child's treatment plan. Your willingness to follow home program requests bears directly on the success of your child's treatment.

- You are responsible for arranging payment for the services you receive.

- You are responsible for keeping your schedule appointments. If your child cannot keep an appointment, please advise us as soon as you can. We recognize that children get sick unexpectedly and miss scheduled appointments. Autism Systems does reserve the right to discharge your child when three out of four consecutive appointments are missed without advance notice. Therefore, you must advise scheduling as soon as possible whenever your child is unavailable for a scheduled appointment.

- You are responsible for respecting the right of privacy and confidentiality of other clients in our center. This is especially true of other clients you meet while participating in group situations in settings outside of the center.

- You are responsible to help us assure that our therapy center feels safe and all are protected. Autism Systems reserves the right to terminate contact with individuals who engage in abusive language or behavior, any form of harassment or who are perceived to be under the influence of alcohol or drugs.

Health Insurance Portability and Accountability Act Privacy Notice (HIPAA)
(Parent Copy)

This notice describes how Autism Systems uses and discloses your medical and other indentifying Protected Health Information (PHI). In addition, this notice describes your legal rights in regards to your records, and the process for accessing your records. Please review this notice carefully.

As part of providing services, Autism Systems will collect PHI about your child's health care and your family. Autism Systems needs this PHI to provide quality services and to comply with certain legal requirements. This notice applies to all records generated by Autism Systems. This law requires us to:

- Make sure that records with identifying PHI are kept private.
- Give you this notice of our legal duties and privacy practices with respect to PHI; and
- Follow the terms of the Privacy Notice that is currently in effect.

How Autism Systems May Use and Disclose PHI

Listed below are a number of reasons or ways in which Autism Systems may disclose PHI. In each category, there is an explanation of the reason and usually an example. This notice does NOT LIST EVERY USE OR DISCLOSURE IN A CATEGORY. The reasons Autism Systems might disclose PHI includes:

>For Treatment: Autism Systems may disclose PHI to Autism Systems personnel or outside of Autism Systems to others who are involved in providing care to you or your child. For example, Autism Systems Senior Therapists meet weekly to discuss challenging behaviors and programming and may share PHI at that time. In addition, with written consent, Autism Systems may communicate with your child's County Case Manager.

>For Payment: Autism Systems may use and disclose PHI so that services may be billed and payment may be collected from an insurance company or a government health program. Autism Systems may also tell your health plan about a service your child may receive to obtain prior approval or to determine whether your health plan will cover the treatment. As legal guardians, you must provide informed consent for Autism Systems to release this PHI.

>For Health Care Operations: Autism Systems may use Autism Systems to run our program and to make sure Autism Systems is providing quality services or to decide if services should be changed or modified.

>As Required by Law: Autism Systems will disclose PHI when required by federal, state, or local law. For example, state law requires Autism Systems to report suspected abuse or neglect to the proper authorities, which will require the release of PHI. This use of PHI does not require consent.

>To Avoid a Serious Threat to Health or Safety: Autism Systems may use or disclose PHI when necessary to prevent a serious threat to your child's health and safety or the health and safety of the public or another person. As legal guardians, you will have the opportunity to provide written consent for this use of PHI.

>Military and Veterans: If you are a member of the armed forces, Autism Systems may release PHI about you as required by military command authorities without additional consent.

>Workers' Compensation: Autism Systems may release PHI for workers' compensation or similar programs when required by law to do so. For example, if you are involved in a claim for workers' compensation benefits, Autism Systems may release PHI requested about your child's health.

>Health Oversight Activities: Autism Systems may disclose PHI to a health oversight agency for activities authorized by law. Examples are government audits, investigations, inspections and licensure.

>Lawsuits and Disputes: If you are involved in a lawsuit or dispute, or if there is a lawsuit or dispute concerning our services or someone who provided services to you. Autism Systems may disclose PHI in response to a court or administrative order. Autism Systems may also disclose PHI in response to a subpoena, discovery request, or other lawful process from someone else involved in the dispute, but only if efforts have been made to inform you about the request prior to providing the PHI to allow you to obtain an order protecting the PHI requested.

>Law Enforcement: In certain situations, Autism Systems may release PHI to law enforcement officials. For example, Autism Systems might release PHI about you to identify or locate a missing person; about a death at Autism Systems that may be the result of criminal conduct; or in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description of location of the person believed to have committed the crime.

>Coroners, Medical Examiners and Funeral Directors: Autism Systems may release PHI to a coroner or medical examiner to identify a deceased person or determine a cause of death Autism Systems may release PHI to funeral directors as necessary to help them carry out their duties.

>National Security and Intelligence, Protective Services for the President and Others: Autism Systems may release PHI to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

>Correctional Programs: If you are an inmate or in the custody of a law enforcement officer, Autism Systems may release PHI to the correctional institution or law enforcement official, to protect your health and safety or the health and safety of others.

Your Rights and Your Child's Rights Regarding Your Protected Health Information

As legal guardians for your child, you have the following rights:

1. To Inspect and Copy Autism Systems Service Records: Usually this includes medical and billing records but may exclude psychotherapy notes. To inspect and copy PHI in your record you must submit a request in writing to the center Director or HIPAA Compliance Officer. Autism Systems is allowed to charge a reasonable fee for the costs of copying, mailing or other costs related to your request.

In very limited circumstances Autism Systems may deny your request. If Autism Systems denies your request you may ask that the denial be reviewed. Another licensed health care professional of Autism Systems will then review your request and either uphold the original decision or reverse it.

2. To Amend your Records: If you believe that the PHI Autism Systems has about you and/or your child is incorrect or incomplete; you may make a written request to the HIPAA Compliance Officer to amend the PHI. You must include a reason that supports your request.

Autism Systems may deny the request if it is not in writing or does not include reasons to support the request. Autism Systems may also deny your request if you ask us to amend PHI that:

- was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
- is not part of the PHI kept in our file;
- is not part of the PHI you would be permitted to inspect and copy or
- Autism Systems believes the PHI is accurate and complete.

If you disagree with the denial, you may submit a statement of disagreement. If you request an amendment to your record Autism Systems will include your request in the record, whether the amendment id accepted or not.

3. To Receive an Accounting of Disclosures: Autism Systems will keep a log of disclosures made on or after November 1, 2011, other than disclosures for treatment, billing or health care operations. You have the right to request the list of disclosures. You must submit a written request to the HIPAA Compliance Officer. The request may not cover more than a six-year period.

4. To Request Restrictions: You may request a restriction on the disclosure of PHI for treatment, payment or health care operations. Your request must be in writing to the HIPAA Compliance Officer. Your request must clearly state 1) what PHI is to be limited 2) whether you want to limit our use, our disclosure or both; and 3) to whom you want the limit to apply. For example, you could ask Autism Systems not use or disclose PHI to a certain person about services your child has received.

Autism Systems does not have to agree to your request to restrict access to PHI. If Autism Systems does agree, Autism Systems will comply with your request unless the PHI is needed to provide emergency treatment or to comply with a lawful and legal request or investigation.

5. To Request Alternative Ways to Communicate: You may request that Autism Systems communicate with you about services in a certain way or at a certain location. For example, you can ask that Autism Systems contact you only at work or only by mail. Your request must be in writing, must tell us how you would like us to communicate with you, and must be sent to the HIPAA Compliance Officer. Autism Systems with accommodate all reasonable requests.

6. To Received a Paper Copy or Electronic Copy of this Notice: You have the right to receive a paper or an electronic copy of this notice from the HIPAA Compliance Officer.

Additional Rights Under State Law

State privacy laws may provide additional privacy protections. Any such protections will be attached in a separate State addendum to this Notice.

Changes to this Notice

Autism Systems may change this notice in the future. Autism Systems can make the revised or changed notice effective for PHI Autism Systems already has about you as well as any PHI Autism Systems may create of receive in the future.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the HIPAA Compliance Officer or with the Secretary of Health and Human Services. All complaints must be in writing. Autism Systems will not retaliate against you for filing a complaint.