Developmental Therapy Center

General Developmental History

Date: _____/_____/_____
Month Day Year

Basic Client Information

Client Name: _____

Medical Record Number: _____
If Applicable

Birth Date: _____ /_____ /_____
Month Day Year

Chronological Age: _____

Sex: ☐ Male ☐ Female ☐ Intersex

Gender Identity: ☐ Male ☐ Female ☐ Other: _____
Please self-describe

Ethnicity:
Please select all that apply

☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Middle Eastern
☐ Native American or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Prefer not to disclose
☐ White
☐ Other: _____

Biological Mother's Name: _____

Biological Father's Name: _____

Contact Information

Client's Primary Residence Address: _____
Street

_____ _____ _____
City State Zip Code

Client's Secondary Residence Address: _____
If Applicable
Street

_____ _____ _____
City State Zip Code

Primary Client Contact: _____

Phone Number: _____ Email Address: _____

NOTE: The phone number and email address above will be the primary contact(s) used by DTC for, among other things, rescheduling, notifications, etc.

Secondary Client Contact: _____

Phone Number: _____ Email Address: _____

Family Background

Does Client have any siblings? ☐ Yes ☐ No

If Yes, please list all siblings and their ages:

Please list all languages spoke by Client's caregivers and/or within Client's residence(s):

Please describe Client's living situation:

Is there any medical treatment history (previous or current) in Client's family that may be pertinent to the condition/treatment of Client? *(e.g.,, drug or alcohol abuse, tobacco use, gambling addiction, etc.)* ☐ Yes ☐ No

If Yes, please explain:

Are there any spiritual and/or cultural variables that may impact Client's treatment and/or that staff needs to be aware of? *(e.g.,, religious holidays when services cannot be provided, gender preferences, etc.)* ☐ Yes ☐ No

If Yes, please explain:

Are there any legal issues relevant to Client and/or Client's family staff needs to be aware of? ☐ Yes ☐ No

(e.g.,, pending marital status change, change in living arrangements, pending change in physical/legal custody, etc.)

If Yes, please explain:

School/Day Care Attending: _____

Grade Level/Days per week: _____

Teacher's Name: _____ School Phone: _____

Medications: _____

Medical Diagnosis: _____ Seizure History: _____

Allergies: _____

Special Diet/Dietary Restrictions: _____

_____

Major Illness, Surgeries, or Hospitalizations: _____

_____

Primary Care Provider: _____ Provider Phone: _____

Names, disciplines and phone numbers of specialists working with client (Speech-Language Pathologist, ABA provider, PT, developmental pediatrician, mental health, etc.) Continue on below or reverse side if needed.

Name	Discipline/Profession	Phone Number	Dates of Service	Outcome (Discharged etc.)

Basic Information

Please describe the concerns regarding client that brought you here today:

Are you aware of any mental illness, developmental disorders, speech, language, or hearing problems in your family? ❑ Yes ❑ No

If yes, please describe:

Please describe the conditions of your pregnancy and client's birth:
(e.g., full term, vaginal delivery, preeclampsia, maternal stress, baby's weight, etc.)

Has client had any major or notable falls (from greater than 4 feet) or bumps to the head? ❑ Yes ❑ No
(e.g.,, fell off changing table, swing, slide, etc.)

If yes, please explain:

Physical Development

Please note the approximate age when client achieved the following skills:

Held head up while lying on stomach:	_____	Rolled over alone:	_____
Sat Unsupported:	_____	Belly Crawling:	_____
Crawling:	_____	Stood Alone:	_____
Cruising:	_____	Walking:	_____

First words:	_____	Talking	_____
Fed self with spoon:	_____	Running:	_____
Jumping:	_____	Skipping:	_____
Riding a Tricycle:	_____	Riding a 2-wheeled bike:	_____

Hearing

Does client have a history of recurrent ear infections? ❑ Yes ❑ No

If yes, how were they treated?
(e.g.,, antibiotics, ear tubes, etc.)

Dates and results of last hearing test:

Comprehension

How well does client understand you? Others?

Does client respond to inhibitory commands (*e.g.,* no, wait, stop)?

Does client follow:

- ❑ simple commands (*e.g.,* put that away)?
- ❑ 2-step directions (*e.g.,* get your shoes and brush your hair)?
- ❑ 3-step directions (*e.g.,* pick up your toys, brush your teeth and get in bed)?

Does client respond to yes/no questions?

Does client respond to his/her name?

Play/Social

Describe client's play:
(e.g., preferred toys, activities, people involved and time spent per day in these activities, solitary/with others)

❑ Yes ❑ No

Does client have a strong desire for structure or control?

How does client adjust to new environments and individuals?

Please describe things that make client upset and what helps calm him/her:

How does client adjust to new environments and individuals?

If so, please describe:

Does client exhibit aggressive or destructive behaviors (directed at self or others)? ❑ Yes ❑ No

If so, please describe:

Does client exhibit repetitive behaviors (*e.g.,* flapping arms, spinning)? ❑ Yes ❑ No

If so, please describe:

Is client often frustrated, anxious or overwhelmed? ❑ Yes ❑ No

If so, how can you tell?

Are transitions difficult for client? ❑ Yes ❑ No

The following questions are an opportunity to share your thoughts about client with us. Please fill this out to the best of your ability, keeping in mind there are no right or wrong answers.

Tells us about your understanding of client's condition or development:

With the above information in mind, what would you like to see client doing in six (6) months that s/he is not doing now?

Developmental Therapy Center

Informed Consent to Treatment

Name of Client: _____ ("Client") Birth Date: _____ /_____ /_____
Month Day Year

DTC communicates information regarding the treatment services it intends to provide to each of its clients, and/or their legally authorized representative(s), to enable an informed decision about whether to accept such treatment services. As used in this form, the terms "I," "you" and "Client" include both the person receiving services (Client) and/or Client's legally authorized representative, as applicable.

DTC encourages you to carefully review this form and ask any clarifying questions before signing it. Treatment will not begin until you have the opportunity to receive this information and give informed consent. In addition, you have the right to give or refuse consent to any proposed treatment at any time prior to its performance.

Certification of Authority

I, the undersigned, am the parent, legal guardian, and/or authorized representative of Client, who is an unemancipated minor person under eighteen (18) years of age, or other person without legal capacity.

_____ Initials — I certify that I am legally authorized to make medical decisions for Client, I have provided DTC with truthful, current, accurate and complete information and/or documentation of that authority, and DTC is entitled to rely on such information and/or documentation in determining whether to provide services.[1]

_____ Initials — I will indemnify, defend and hold harmless DTC, and its affiliates, agents, employees and representatives, against any and all claims, damages, expenses, losses and liabilities whatsoever that DTC incurs or suffers as a result of its reliance on the information and/or documentation I have provided.

_____ Initials — I unconditionally and forever release DTC, and its affiliates, agents, employees and representatives from all claims, proceedings, causes of action, obligations and liabilities whatsoever that arise from, or relate to, my authority to give consent for Client's treatment.

_____ Initials — I have received, read and understood DTC's Registration Package, which includes the General Information, Policies and Procedures and Notice of Privacy Practices. I will abide by all DTC policies and requirements provided therein. I may request an explanation and/or copies of the materials again, at any time.

Consent to Treatment

I understand consent is required prior to the planning and/or implementation of behavioral health and/or and other treatment services by DTC for the benefit of Client. I also understand treatment is entirely voluntary and may be terminated at any time.

_____ I acknowledge and agree DTC adequately explained the proposed treatment (including specifically, but not limited to, information regarding the nature and goals of the treatment program, the manner/method of treatment, qualifications and responsibilities of staff, typical times, days and location(s) of treatment, duration of treatment); the benefits, risks, and likelihood of achieving treatment goals (including, specifically, the risk of noncompliance with treatment recommendations); reasonable alternatives and their risks and benefits

[1] I will notify DTC, as soon as practicable, if my legal authority to sign this document for, and/or on behalf of, Client is revoked, reduced, or otherwise modified.

(including the possibility of refusing treatment); and I was able to ask questions and obtain all of the information I needed about the proposed treatment.

BY SIGNING BELOW, I CONSENT TO AND AUTHORIZE DTC, AND/OR ANY QUALIFIED PROVIDER(S) DESIGNATED BY DTC, TO ADMINISTER OCCUPATIONAL THERAPY, PHYSICAL THERAPY AND/OR SPEECH THERAPY, AS DEEMED NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND/OR TREATMENT OF ANY CONDITION(S) RELATED TO CLIENT. I UNDERSTAND THIS CONSENT IS VALID AND IN EFFECT UNTIL SUCH TIME I WITHDRAW IT IN WRITING OR IN PERSON. I FURTHER REPRESENT AND WARRANT I HAVE THE FULL LEGAL AUTHORITY TO SIGN THIS DOCUMENT FOR, AND/OR ON BEHALF OF, CLIENT.

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Developmental Therapy Center

Services Agreement - Insurance

This Services Agreement ("Agreement") is entered into by and between Developmental Therapy Center, Inc., a California corporation d.b.a. DTC ("DTC") and:

Name(s) of Responsible Party or Parties: (collectively "Responsible Party")	_____
	_____

On behalf, and for the benefit, of:

Name of Client:	_____ ("Client")
Date of Birth:	_____ /_____ /_____ (Month Day Year)
This Agreement is effective as of:	_____ /_____ /_____ (Month Day Year) (the "Effective Date")

1. Scope of Services. Subject to the terms of this Agreement, and any attachments hereto or incorporated by reference herein, DTC hereby agrees to provide Client with treatment and/or other related services (collectively or individually "Services").

2. Insurance. After receiving a completed verification of benefits package, DTC will, as a courtesy, contact Client's health care service plan ("Insurance Provider"), to determine whether coverage exists for Services under the applicable health care plan. If coverage exists, and Responsible Party hereby agrees DTC may submit claims for Services to the applicable Insurance Provider. Notwithstanding any insurance coverage, Responsible Party shall remain responsible for payment of any deductible, co-payment, co-insurance and/or any other fees applicable under the applicable health insurance plan. Responsible Party shall notify DTC of any change in Insurance Provider or health care plan within twenty-four (24) hours of any such change.

   2.1. Assignment of Benefits. Responsible Party shall complete any and all necessary forms required by DTC, or Insurance Provider, to submit claims for payment of insurance benefits and shall assign to DTC any and all medical health benefits, including any major medical benefits, related to the Services.

   2.2. Responsibility for Full Payment for Services. Responsible Party understands he/she is ultimately responsible for payment for any Services rendered that are not covered by their insurance contract (e.g., if coverage for Services is denied, in whole or in part, by the Insurance Provider for any reason), unless otherwise prohibited by the health care plan contract or applicable law. DTC makes no representations that any other party is or might be responsible for payment of all or any part of the Services rendered.

3. Consent. Responsible Party consents to any/all Services not requiring informed written consent.

4. Pre-Authorized/Authorized Services. Responsible Party hereby authorizes DTC to provide any and all Services pre-authorized and/or authorized by Client's Insurance Provider.

   4.1. Additional Services. In the event Responsible Party requests DTC provide Services in addition to, or that exceed, the Services pre-authorized and/or authorized by Client's Insurance Provider ("Additional Services"), Responsible Party agrees to pay DTC directly for any and all such Additional Services; unless otherwise

prohibited by the health care plan contract or applicable law.

5. Fees. Responsible Party hereby agrees to the pay DTC for any deductible, co-payment, co-insurance and/or any other fees applicable under the applicable health insurance plan (collectively, the "Insurance Fees"). Further, Responsible Party agrees to the pay DTC for Additional Services at the lesser of the negotiated rates set forth in the health care plan contract, or the rates set forth in DTC then current fee schedule.

   5.1. Initial Retainer. If coverage by an Insurance Provider is undetermined, disputed or pending, DTC may require pre-payment of fees prior to the commencement of Services ("Initial Retainer"). If Responsible Party does not wish to pay an Initial Retainer in such circumstances, Services may be put on hold pending pre-authorization or authorization from the Insurance Provider.

   5.2. No-Show/Late Cancellation. If Client fails to attend a scheduled appointment, or if a scheduled appointment is canceled with less than 24-hours notice, Responsible Party agrees to pay DTC a cancellation fee of $45.00. This Paragraph 5.2 shall not apply in circumstances where such charges are prohibited by health care plan contract or applicable law. The first late, no show or cancel fee is $45.00, second is $90.00 and the third is $150.00.

6. Billing/Payment. DTC will provide Responsible Party a monthly statement setting forth the Services provided and fees incurred during the prior month ("Statement"). Payment in full is due to DTC within fourteen (14) calendar days of the date set forth on any Statement ("Statement Date"). All fees must be paid directly to DTC by check, money order or credit card.

   6.1. Past Due Statements. Responsible Party agrees to provide DTC with a valid credit card number and authorization to charge any and all fees to the credit card if the fees remain unpaid after fourteen (14) calendar days from Statement Date ("Past Due Statements").

   6.2. Collections. DTC may, at its sole discretion, refer any Statement that remains unpaid after thirty (30) days of the Statement date to an attorney or other party for collection. In such circumstances, Responsible Party shall be responsible to pay DTC all attorneys' fees and/or other costs of collection. Past Due Statements not paid shall bear interest at the rate of ten percent (10%) per annum, or the maximum rate permitted by applicable law, whichever is less, beginning on the fifteenth (15th) calendar day following the Statement date.

   6.3. Billing Disputes**.** If Responsible Party does not notify DTC, in writing, of any objection to the information reflected on any Statement (including, without limitation, any error or unauthorized activity on Responsible Party's account(s)) within thirty (30) days of the Statement date, DTC will assume the Statement is correct and that Responsible Party approves of the Services rendered/charged. Responsible Party agrees to waive any objection to the amount of, or basis for, any charge(s) so approved and acknowledges DTC will be relying upon approval of these Statements in electing to continue to render Services under the terms of this Agreement.

   6.4. Conflict of Interest; Local Education Agency Services. If Client is receiving Services from a Local Education Agency ("LEA") in which DTC is the Non-Public Agency Service Provider and Responsible Party seeks supplemental Services from DTC through this Agreement, Responsible Party is responsible to ensure Client's Individualized Education Plan ("IEP") provides Free Appropriate Public Education ("FAPE") and agrees the Services provided pursuant to this Agreement are supplemental and non-related. Responsible Party agrees to pay for the Services in accordance with the terms of this Agreement and understands and, unless otherwise agreed upon in writing between Responsible Party and the LEA, agrees not to seek reimbursement from the LEA for the supplemental Services provided by DTC.

7. Polices and Procedures. Responsible Party agrees to abide by any and all policies and/or procedures set forth in Exhibit A, attached hereto and incorporated by reference herein, as well as any and all DTC'S policies and procedures as may be communicated to Responsible Party from time to time.

8. Term. The term of this Agreement shall commence on the Effective Date and shall continue on a monthly basis thereafter (the "Term") until terminated by either party in accordance with the provisions of Section 10, below.

9. Termination. Responsible Party may terminate Services for any reason, or no reason, upon providing thirty (30) days' prior written notice to DTC. DTC may terminate Services for any reason, or no reason, upon providing thirty (30) days' prior notice to Responsible Party, or immediately for cause (as determined in DTC sole discretion) unless otherwise required by health care plan contract or applicable law.

10. Miscellaneous.

    10.1. Authority. If the Client is a minor person under eighteen (18) years of age, or other person without legal capacity, Responsible Party represents and warrants he/she/they have the legal authority to sign this Agreement for and on behalf of the Client.

    10.2. Jurisdiction; Disputes. This Agreement shall be governed by and construed in accordance with the laws of the State of California. In the event of any dispute arising from the terms of this Agreement, the venue shall be in San Diego County, California.

    10.3. Attorneys' Fees and Costs. Should any litigation, arbitration, mediation, or other dispute resolution proceeding (collectively "Proceeding") be commenced between the Parties hereto to enforce or interpret this Agreement or concerning this Agreement or the subject matter hereof or the rights and duties of the Parties in relation hereto or thereto, the Party prevailing in such Proceeding (whether at trial or on appeal) shall be entitled, in addition to such other relief as may be granted, to its costs and expenses of participation in such Proceeding, including without limitation a reasonable sum as and for its attorneys' fees and costs in such Proceeding, which shall be determined by the court or other trier of fact in such Proceeding or in a separate action brought for that purpose.

    10.4. Severability. Any provision of this Agreement found to be void, invalid or unenforceable shall be severed and shall not affect the other provisions of this Agreement, and the Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

    10.5. Waiver. The waiver by any party to a breach of any provision of this Agreement must be in writing and signed by such party to be effective, and shall not operate or be construed as a waiver of any subsequent breach of this Agreement.

    10.6. Entire Agreement of the Parties. This Agreement supersedes any and all agreements, either oral or written, between the Parties hereto with respect to the rendering of Services by DTC and contains all of the covenants and agreements between the Parties with respect to the rendering of such Services in any manner whatsoever. Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, orally or otherwise, have been made by any party, or anyone acting on behalf of any other party, that are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Any modification of this Agreement will be effective only if it is in writing signed by the party to be charged.

    10.7. Interpretation. In construing this Agreement, each number and gender shall include each other number and gender, section/paragraph captions shall not be considered a part of the Agreement or affect its interpretation, and its provisions shall not be interpreted in favor of or against either Party based on who prepared or drafted the Agreement or for any other reason.

    10.8. Further Action. Each party hereto agrees to perform any further acts and to execute any documents, which may be reasonably necessary to carry out the provisions of this Agreement.

    10.9. Parties in Interest. This Agreement shall bind and inure to the benefit of the Parties, their successors and assigns.

    10.10. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which together shall be the same document. Such counterparts may be executed and delivered in person or via facsimile.

    10.11. Headings. The headings of this Agreement are for purposes of reference and convenience only and shall not limit or otherwise affect the meaning hereof.

BY SIGNING THIS AGREEMENT I/WE ACKNOWLEDGE THAT I/WE HAVE READ, UNDERSTOOD AND AGREED TO ALL OF ITS TERMS.

Client's Name: _____ Birth Date: _____ /_____ /_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Internal Use Only

Referred by:_____

Developmental Therapy Center

Consent for Emergency Medical Treatment

Name of Client: _____ ("Client") Birth Date: _____ /_____ /_____
Month Day Year

Consent for Emergency Medical Treatment

In case of a medical emergency (*i.e.,* where the Client needs immediate medical attention) as determined by DTC, I/we hereby authorize DTC to contact emergency medical personnel and arrange for emergency medical care.

I/we further authorize all medical and surgical treatment, x-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for Client and waive my right to informed consent of treatment, which waiver shall apply only in the event that a Responsible Party cannot be reached in the case of an emergency.

BY SIGNING THIS AGREEMENT I/WE ACKNOWLEDGE THAT I/WE HAVE READ, UNDERSTOOD AND AGREED TO ALL OF ITS TERMS.

Client Name: _____

Client Birth Date: _____ /_____ /_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Developmental Therapy Center

Telephone Communication and Voice Messages

Developmental Therapy Center will frequently call you to discuss matters related to client's therapy program. To protect your privacy, please indicate your preferences as to how we should contact you.

Please call:

- ❑ my home phone: _____
- ❑ my work phone: _____
- ❑ my cell phone: _____

If you are unable to reach me:

- ❑ You may leave a detailed message.
- ❑ Please leave a general message asking me to return your call.
- ❑ Other: _____

The best time to reach me is (day) _____ between (time)_____.

Client's Name:	_____	Birth Date:	_____ /_____ /_____ Month Day Year
Responsible Party Name:	_____		
Relationship to Client:	_____		
Responsible Party Signature:	_____	Date:	_____ /_____/_____ Month Day Year

Developmental Therapy Center

Appointment/Closure Reminders

Developmental Therapy Center, Inc. (DTC) has the ability to provide you with text message or email reminders of upcoming appointments and/or office closures. To protect your privacy, we request you select one of the following:

☐ Please contact me by text message at: _____

☐ Please contact me by email at: _____

☐ Please do not send me reminders of upcoming appointments and/or office closures by text message or email.

Client's Name: _____

Client Birth Date: _____ /_____ /_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____ /_____
Month Day Year

Developmental Therapy Center

Credit Card Payment Authorization

Name of Client: _____ ("Client") Birth Date: _____ /_____ /_____
Month Day Year

Cardholder Name: _____

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Other
_____

Expiration Date: _____ Security Code: _____

Card Number: _____

Billing Address: _____
Street

_____ _____ _____
City State Zip Code

By signing below, I hereby authorize DTC to charge/debit my credit card for any and all missed appointments where client(s) either fail(s) to show up for a scheduled appointment, or cancels a scheduled appointment with less than 24-hours advance notice. I understand missed and/or canceled appointment fees are billed in the minimum amount of $45.00.
I hereby further authorize DTC to charge/debit my credit card for the following (please select one or more of the following):

☐ Any and all co-payments, co-insurance and/or deductibles as required and/or set by my health insurance provider.

☐ Any and all additional services rendered pursuant to the Service Agreement, as amended, at the time additional services are rendered or when a statement is greater than ten (10) calendar days past due.

I understand this authorization will remain in effect until I cancel it in writing, and I agree to notify DTC, in writing, of any changes in my account information, or termination of this authorization, at least fifteen (15) days prior to the next billing date.

I agree not to dispute this recurring billing with my credit card company so long as the transactions correspond to the terms indicated in this authorization form. If necessary, I authorize DTC to initiate adjustments for any transactions credited or debited in error.

Card Holder Signature: _____ Date: _____ /_____ /_____
Month Day Year

Developmental Therapy Center

Assignment of Benefits

Name of Client:	_____ ("Client")
Primary Insured Birth Date:	_____ /_____ /_____ Month Day Year
Name of Primary Insured:	_____
Provider Name:	_____
Policy Number:	_____
Group Number:	_____ (if applicable)

I, the undersigned, on behalf of myself and/or on behalf of Client, have treatment and/or other related services (collectively or individually "Services") from Developmental Therapy Center, Inc. ("DTC") and understand that by making this request I am financially responsible for any and all charges incurred in the course of any and all authorized treatment.

I further understand that fees for all professional services are due and payable on the date services are rendered, unless other payment arrangements have been made in advance with DTC; in which case I agree to pay any and all charges incurred, in full, immediately upon presentation of a statement.

Assignment of Benefits
I agree to complete any and all necessary forms required by DTC, or my health insurance plan(s), to submit claims for payment of insurance benefits and hereby assign any and all medical and/or behavioral health benefits, including any major medical benefits to which I am entitled, or to which Client is entitled, to DTC. I hereby authorize and direct my health insurance provider(s) (including Medicare, private insurance and any other health/medical plan), to issue payment check(s) for covered services rendered to myself and/or Client, regardless of my insurance benefits, if any, directly to DTC. I understand it is my responsibility to immediately report any changes in insurance coverage to DTC. A photocopy of this assignment is to be considered as valid as the original.

Authorization to Release Information
I hereby authorize DTC to: 1) communicate with and disclose/release any confidential/protected health information related to my condition and/or treatment(s) as requested/required by my health insurance provider(s); 2) process any and all claims generated in the course of examination or treatment; and 3) allow a photocopy of my signature to be used to process claims for payment submitted to my health insurance provider(s).

I understand this form will be kept on file with DTC and/or my health insurance provider(s) and this authorization and order will remain valid and in effect until revoked in writing, signed by me, and delivered to DTC.

BY SIGNING THIS AGREEMENT I ACKNOWLEDGE THAT I HAVE READ, UNDERSTOOD AND AGREED TO ALL OF ITS TERMS.

Insured Party Name: _____
Print

Relationship to Client: _____

Insured Party Signature: _____ Date: _____ /_____ /_____
Month Day Year

Developmental Therapy Center

Photograph/Videotape Authorization and Release

Name(s) of Responsible Party or Parties: (collectively "Responsible Party") _____
_____

Name of Client: _____ ("Client") Birth Date: _____ /_____ /_____
Month Day Year

Responsible Party understands and agrees that by entering the premises and/or facilities (the "Facilities") occupied and/ or operated by Developmental Therapy Center, Inc. ("DTC") and/or participating in any sessions, programs or other activities conducted and/or sponsored in whole or in part by DTC, whether conducted within or outside of the Facilities (collectively the "Activities"), Responsible Party and/or Client may have his/her/their likeness captured through videotape (including audio) and/or photograph, either digitally or in any other medium, now known or later discovered (collectively "Images"). From time to time, DTC may desire to use the Images for, among other things, clinical, educational or advertising purposes.

Responsible Party, on behalf of himself/herself/themselves, and on behalf of Client, hereby consents to and authorizes DTC and/or its agents, employees, independent contractors, designees or persons acting under its direction, to capture the Images while Responsible Party and/or Client are present at the Facilities and/or participating in the Activities. Responsible Party understands and agrees that by executing this authorization and release, Responsible Party is agreeing on behalf of himself/herself/themselves, and on behalf of Client, that any and all rights in the Images (including, but not limited to, copyrights or any other rights attaching thereto), shall be the sole and absolute property of DTC only.

Responsible Party on behalf of himself/herself/themselves, and on behalf of Client, further hereby authorizes, and irrevocably grants, DTC the right to distribute, transmit, publish, display, copy, alter, modify, use or otherwise exploit the Images, or any derivative works thereof, either in whole or in part, either digitally or in any other medium, for (*please check one or more of the following*):

- ❑ **Any and all purposes**
- ❑ **Advertising materials only**
  (e.g. DTC'S website, posters, promotional flyers, brochures, etc.)
- ❑ **In-house educational purposes only**
  (e.g. use and/or collaboration with DTC'S, or its affiliates', staff to enrich Client's therapy program)
- ❑ **Interdisciplinary collaboration, research and/or educational purposes only**
  (e.g. to share with other relevant professionals (e.g. outside of DTC))
- ❑ **I do not authorize DTC to use the Images**

Responsible Party hereby waives, on behalf of himself/herself/themselves, and on behalf of Client, any and all legal or monetary interest arising from creation or use of the Images and acknowledges his/her/their understanding that he/she/ they shall never be entitled to any compensation or additional consideration in any fashion for the use of his/her/their and/ or Client's likeness.

Responsible Party on behalf of himself/herself/themselves, and on behalf of Client, hereby releases and discharges DTC and its owners, shareholders, managers, directors, officers, employees, partners, affiliates, subsidiaries, independent contractors, agents, representatives, attorneys, insurers, successors, and assigns from any claim or cause of action, now known or later discovered, for, among other things, invasion of privacy, right of publicity, and defamation arising out of the use and exploitation of the Images.

BY SIGNING THIS AGREEMENT I/WE ACKNOWLEDGE THAT I/WE HAVE READ, UNDERSTOOD AND AGREED TO ALL OF ITS TERMS.

Client's Name:	_____	Birth Date:	_____ /_____ /_____ Month Day Year
Responsible Party Name:	_____		
Relationship to Client:	_____		
Responsible Party Signature:	_____	Date:	_____ /_____/_____ Month Day Year
Responsible Party Name:	_____		
Relationship to Client:	_____		
Responsible Party Signature:	_____	Date:	_____ /_____/_____ Month Day Year

Developmental Therapy Center

Authorization for Pick-up

Name of Client: _____ ("Client") Birth Date: _____ /_____ /_____
Month Day Year

This authorization is effective as of: _____ /_____ /_____ (the "Effective Date").
Month Day Year

I, the undersigned, certify that: (i) I am at least eighteen (18) years of age; and (ii) I am the parent or legal guardian of the Client, or I have obtained written permission from the parent or legal guardian of the Client to execute this agreement on behalf of such parent or legal guardian.

I hereby authorize the following person(s) to pick-up Client from the DTC clinic. I understand it is my responsibility to notify DTC in writing of any additions to or deletions from the following list. I further understand this authorization may only be modified or revoked in writing (*i.e.,* a phone call may not be accepted as authorization for someone to pick-up Client).

Name	Relationship to Client	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

BY SIGNING THIS AGREEMENT I/WE ACKNOWLEDGE THAT I/WE HAVE READ, UNDERSTOOD AND AGREED TO ALL OF ITS TERMS.

Client's Name: _____

Client Birth Date: _____ /_____ /_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Developmental Therapy Center

Facilities Use and Participation Agreement

Name(s) of Responsible Party or Parties: (collectively "Responsible Party") _____
_____

On behalf, and for the benefit, of:

Name of Client: _____ ("Client") Birth Date: _____ /_____ /_____
Month Day Year

This authorization is effective as of: _____ /_____ /_____ (the "Effective Date").
Month Day Year

In consideration of being allowed to enter and use the facilities (the "Facilities") of Developmental Therapy Center, Inc. ("DTC") and/or participate in any sessions, programs or other activities conducted and/or sponsored in whole or in part by DTC, whether conducted within or outside of the Facilities (collectively the "Activities"), the Responsible Party, on his/her/their behalf, and on behalf of Client, acknowledges and agrees to the following:

1. Affirmation of Authority

Responsible Party certifies that: (i) Responsible Party is at least eighteen (18) years of age; and (ii) is the parent or legal guardian of the Client, or Responsible Party has obtained permission from the parent or legal guardian of the Client to execute this agreement on behalf of such parent or legal guardian.

2. Assumption of Risk

Responsible Party certifies that both the Client and Responsible Party are in good physical condition and are safely able to participate in the Activities.

Responsible Party certifies he/she/they is/are fully aware, understand and acknowledge that engaging in the Activities exposes Responsible Party and/or Client to a variety of inherent dangers and risks, and that by engaging in the Activities, Responsible Party and/or Client may become seriously ill, injured, paralyzed, or die (due to, among other things, the unavailability of emergency medical care or first aid treatment, becoming unconscious or incapacitated, the negligence or deliberate acts of other persons (i.e., third-parties) engaging in the Activities, the lack of supervision of other persons engaging in the Activities, etc.), or may have personal property lost, damaged or destroyed.

Responsible Party, on his/her/their behalf and on behalf of the Client, **KNOWINGLY AND VOLUNTARILY ASSUME ALL DANGERS, RISKS AND HAZARDS** of entering upon or using the Facilities and/or participating or engaging in the Activities, both known and unknown, foreseeable and unforeseeable, including, without limitation, physical illness, injury (including, but not limited to, paralysis) or death, and any loss, damage or destruction of personal property, resulting, directly or indirectly, therefrom, specifically including any and all dangers, risks and hazards that may arise out of the negligence of (i) DTC, (ii) Affiliates (as defined below), or (ii) other participants; except to the extent solely caused by DTC's willful misconduct, gross negligence or violation of law.

Responsible Party acknowledges and accepts full responsibility for his/her/their own safety, and the safety of the Client, while present at the Facilities and/or participating or engaging in the Activities. Responsible Party agrees Client and Responsible Party shall comply with all stated and customary terms, posted safety signs, rules, and verbal instructions as conditions for access to the Facilities and/or participation in any Activities. If Responsible Party observes any actual or

potential hazard during his/her/their presence at the Facilities and/or during the course of the Activities, Responsible Party will immediately bring it to the attention of the nearest DTC employee.
Responsible Party agrees to the foregoing Assumption of Risk is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

3. Release from Liability & Waiver

Responsible Party, on his/her/their behalf and on behalf of the Client, and each of their respective family members, heirs, executors, representatives, administrators, personal representatives, next of kin, insurers, successors, assigns and agents, hereby fully and forever releases, remises, acquits, discharges and holds harmless (i) DTC and its owners, shareholders, managers, directors, officers, employees, partners, affiliates, subsidiaries, independent contractors, agents, representatives, attorneys, insurers, successors and assigns (jointly and severally called "Affiliates"), (ii) other participants or third-parties and (iii) any sponsoring agencies, and each of them, from and against any and all actions, suits, claims, demands, damages, liabilities, obligations, fines, penalties, debts, judgments and liens, fees and expenses (including attorneys' fees) of every kind whatsoever (including, without limitation, those based upon negligence, wrongful death, premises liability, and breach of warranty), which may now or hereafter exist relating to or arising out of: (i) Responsible Party and/or Client's presence upon or use of the Facilities; (ii) Responsible Party and/or Client's participation or engagement in the Activities, specifically including, without limitation, claims for physical illness, injury (including but not limited to paralysis) or death, and any loss, damage or destruction of personal property, whether suffered by Responsible Party or others; and/or (iii) any limited incidental use and/or disclosure of Responsible Party and/or Client' protected health information while participating or engaging in the Activities; except to the extent solely caused by DTC's willful misconduct, gross negligence or violation of law.

The foregoing is specifically intended to be a general release of all claims, and Responsible Party and the Client waive any rights they may have with respect to unknown claims. Accordingly, Responsible Party, on his/her/their behalf and on behalf of the Client, hereby waive any rights or benefits they may have under California Civil Code Section 1542, and any similar laws, which provides:

A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR.

4. Covenant Not to Sue

Responsible Party, on his/her/their behalf and on behalf of the Client, covenant and agree that neither Responsible Party, nor the Client shall file any claim, lawsuit or other proceeding, whether judicial or administrative, for any personal injury, death, property damage, loss, or other injury or damage suffered by Responsible Party or the Client (including but not limited to negligence, wrongful death, premises liability, and breach of warranty claims), as a result of their use or entry upon the Facilities and/or participation or engagement in the Activities, except to the extent solely caused by DTC's willful misconduct, gross negligence or violation of law.

5. Indemnity

Responsible Party, on his/her/their behalf and on behalf of the Client, specifically agree to indemnify, defend, and hold harmless DTC and Affiliates, and each of them, from and against any and all actions, suits, claims, demands, losses, damages, liabilities, obligations, debts, judgments and liens of every kind whatsoever, to which DTC or any Affiliates are subjected, or which may be asserted against DTC or any Affiliates by any person or entity, relating to or arising out of Responsibly Party's and/or Client's entry upon or use of the Facilities and/or engagement or participation in the Activities, specifically including, without limitation, claims for physical illness, injury (including but not limited to paralysis) or death, and any loss, damage or destruction of personal property, or any lack of authority to sign this agreement for and on behalf of Client. Any defense of DTC or Affiliates requires of Responsible Party hereunder shall be by counsel reasonably selected by DTC or the Affiliate(s) being defended, whose fees and costs shall be paid by Responsible Party, and Responsible Party shall not seek any contribution or reimbursement from DTC or Affiliates for such fees or costs.

6. Confidentiality

Responsible Party understands DTC is committed to protecting the identity and privacy of all participants and that as a covered entity, DTC is required to enforce appropriate administrative, technical, and physical safeguards that protect against use and disclosure of protected health information as set forth in federal and state law, including, specifically, a duty to limit incidental use or disclosure of protected health information.

Responsible Party understands that by entering upon or using the Facilities and/or participating or engaging in the Activities, Responsible Party and/or Client may be exposed to personal and/or sensitive information about other participants, including, but not limited to: (i) identifying information about the participant (e.g. name, address, phone number, etc.); (ii) information relating to the participant's family; (iii) information regarding the participant's medical status or diagnosis; (iv) information about the assessment, treatment or intervention received by the participant; or (v) other information that would identify the participant and/or place the participant or participant's family at risk (collectively "Confidential Participant Information").

Responsible Party understands and, on his/her/their behalf and on behalf of the Client, agrees: (i) any and all communications among Responsible Party, Client and DTC's staff and/or between DTC's staff and other clients are intended to be, and are, confidential; (ii) Responsible Party has a duty to keep any and all Confidential Participant Information confidential; and (iii) Responsible Party will not disclose, produce, publish, or reveal any Confidential Participant Information learned or obtained while upon the Facilities and/or participating in the Activities to any third-party without the express written consent of DTC and/or the participant about whom Confidential Participant Information is obtained. Responsible Party understands that Responsible Party's failure to abide by the terms of this provision may result in removal from the Facilities and/or suspension or termination of Responsible Party's and/or Client's ability to enter upon or use the Facilities and/or participate in the Activities, either immediately or in the future.

7. Intellectual Property

Responsible Party understands and, on his/her/their behalf and on behalf of the Client, agrees: that any and all training, teaching or other materials used by DTC while conducting the Activities, and the trademarks, service marks and logos contained in them are owned by or licensed to DTC, subject to copyright and other intellectual property rights under the law. Responsible Party further understands that such materials may not be copied, reproduced, distributed, transmitted, broadcast, displayed, sold, licensed or otherwise exploited for any other purpose whatsoever without the prior written consent of DTC.

8. Non-Disclosure

By entering upon or using the Facilities and/or participating or engaging in the Activities, Responsible Party and/or Client may receive access to certain confidential and/or proprietary information about, and/or in the possession of, DTC, including, but not limited to business, technical or other information, materials and/or ideas, training, teaching or instructional materials, curriculum, programs, employee information, policies, practices and/or procedures, etc. (collectively "DTC's Confidential Information," which term shall include, without limitation, anything learned or discovered as a result of exposure to or analysis of any DTC's Confidential Information).

Responsible Party agrees to hold in complete confidence and not disclose, produce, publish, permit access to, or reveal any DTC's Confidential Information disclosed to Responsible Party and/or Client at any time prior to DTC's intentional public disclosure of that information and agree Responsible Party will not to disclose DTC's Confidential Information to any third party without first obtaining DTC's written consent, which may be withheld in DTC's sole and absolute discretion. Responsible Party agrees to promptly notify DTC of any DTC's Confidential Information prematurely or inappropriately disclosed by Responsible Party and/or Client in breach of this provision.

In the event Responsible Party receives a request to disclose all or any part of the DTC's Confidential Information under the terms of a subpoena, order, civil investigative demand or similar process issued by a court of competent jurisdiction, or by a regulatory or governmental body, or the fact that DTC's Confidential Information has been made available to Responsible Party and/or Client, Responsible Party will, unless prohibited by law, immediately notify DTC of the existence, terms and circumstance surrounding such a request and consult with DTC on the advisability of taking legal available steps to resist or narrow such request.

Upon completion of Responsible Party's and/or Client's use of DTC's Confidential Information, or upon DTC's written request, Responsible Party will immediately discontinue all use of any DTC's Confidential Information and will immediately return any DTC's Confidential Information, in whatever form available, back to DTC.

Responsible Party, on his/her/their behalf and on behalf of the Client, further agrees he/she/they will not interfere with any business of DTC through the use of any information or knowledge acquired in receiving/reviewing DTC's Confidential Information, nor use any DTC's Confidential Information for my own account.

Responsible Party will take all reasonable actions demanded by DTC to remedy any breach of this provision and agrees to indemnify, defend and hold harmless DTC and Affiliates, from and against all loss, damage, liability and expense related to any such breach. Responsible Party understands and, on his/her/their behalf and on behalf of the Client, agree DTC's Confidential Information has been developed or obtained by the investment of significant time, effort and expense and provides DTC with a significant competitive advantage in its business and if Responsible Party fails to comply with any obligations hereunder, DTC will suffer immediate, irreparable harm for which monetary damages will provide inadequate compensation. Accordingly, Responsible Party, on his/her/their behalf and on behalf of the Client, agrees DTC will be entitled, in addition to any other remedies available to it, at law or in equity, to immediate injunctive relief to specifically enforce the terms of this provision.

Responsible Party understands his/her/their duty to protect DTC Confidential Information, other than trade secrets, private financial information, and client names, expires five (5) years from the date of disclosure of DTC's Confidential Information or until all DTC's Confidential Information known to Responsible Party ceases to be within the definition of DTC's Confidential Information, whichever is longer. Responsible Party further understands his/her/their duty to protect DTC's trade secrets, private financial information, and client names shall not expire.

9. Non-Solicitation

Responsible Party agrees he/she/they will not, directly or indirectly, for himself/herself/themselves or on behalf of Client, or in conjunction with, any other person, company, partnership, corporation or business of whatever nature: (i) solicit, induce, recruit or encourage any employee of the DTC to work for any business, individual, partnership, firm, corporation, or any other entity for any reason whatsoever; or (ii) take any action that results, or might reasonably result in any employee, independent contractor, or consultant that provides services to DTC to perform services for Responsible Party or Client.

10. Governing Law, Jurisdiction and Venue

This agreement will be governed by and construed in accordance with the laws of the State of California without reference to its choice of law rules and as if wholly performed within the State of California. Except as otherwise provided in this agreement, any controversy or dispute arising out of this agreement, the interpretation of any of the provisions hereof, or the action or inaction of any party hereunder shall be submitted to arbitration in San Diego, California, pursuant to the commercial arbitration rules of JAMS or ADR Services, Inc. (collectively "Approved Service"), or other recognized arbitration service selected by the party instituting such action provided if any other party objects to the selection of a service other than an Approved Service, the arbitration shall be moved to an Approved Service selected by the party objecting. Any award or decision obtained from any such arbitration proceeding shall be final and binding on the parties, and judgment upon any award thus obtained may be entered in any court having jurisdiction thereof. No action at law or in equity based upon any claim arising out of or related to this agreement shall be instituted in any court by any party except: (a) an action to compel arbitration pursuant to this section, or (b) an action to enforce an award obtained in an arbitration proceeding in accordance with this section.

11. Severability

This agreement is severable and that in the event any provision of this agreement is held to be illegal, invalid or unenforceable, the legality, validity and enforceability of the remaining provisions will not be affected or impaired.

BY SIGNING BELOW, I/WE ACKNOWLEDGE I/WE HAVE CAREFULLY READ THE FOREGOING FACILITIES USE AND PARTICIPATION AGREEMENT IN ITS ENTIRETY, AND UNDERSTAND ITS CONTENTS. I/WE SIGN THIS AGREEMENT VOLUNTARILY AS MY/OUR OWN FREE ACT, WITH FULL KNOWLEDGE OF ITS SIGNIFICANCE, AND INTEND TO BE LEGALLY BOUND BY EACH OF THE PROVISIONS SET FORTH HEREIN.

Client's Name: _____

Client Birth Date: _____ /_____ /_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Developmental Therapy Center

Private Pay Agreement

Thank you for choosing Developmental Therapy Center (DTC) as your service provider! We are excited to begin working with you and your family.

Client will undergo an initial evaluation to determine a plan of care that will best meet his/her needs. The cost of the evaluation varies and depends upon the type of assessment and documentation required. You are responsible for all fees related to your child's therapy.

If therapy services are recommended, the rates will be as follows:

30 Minute Session Treatment Session	$75
60 Minute Session Treatment Session	$175
Full Comprehensive OT Evaluation -30 minutes phone session -60 minutes of testing -60 minutes of clinical observation -90 minutes of report writing -60 minute family meeting	$925
Full Comprehensive ST Evaluation -30 minutes phone session -60 minutes of testing -60 minutes of clinical observation -90 minutes of report writing -60 minute family meeting	$925
Mini Evaluation (1 direct, 1 hour report)	$275
Consult	$200
Re-Evaluation	$250
Report Writing (avg. 30-45 minutes) -Treatment Plan Writing (30 minutes) - Basic Evaluation Writing (60 minutes) -Comprehensive Evaluation Writing (2-3 hours)	$40 (per 15 minutes) $160 (per hour)
Groups (Max 3 clients per txpst)	$100 per child per hour
School Visit (Travel time, visit, coordination)	$125 (per hour)
Parent Meeting	$125 (per hour)
Pre-Pay (multiply duration price by freq recommendation for 1 month)	30 minute session, 60 minute session (10% off)

***15% discount will be given for cash/credit private pay clients.**

The invoice sent to you from DTC will include documentation necessary for you to seek reimbursement from most major commercial insurance companies; however, there is no guarantee your insurance plan will reimburse you in part or in full for the services rendered.

If you have any questions, please contact your local DTC office.

I AGREE AND ACCEPT THE ABOVE TERMS AND SERVICE AGREEMENTS.

Client's Name: _____

Client Birth Date: _____ /_____ /_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Developmental Therapy Center
Phone: (619) 980-4011, Fax (619) 374-2552

Developmental Therapy Center

Authorization for the Use and/or Disclosure of Protected Health Information

Name of Client: _____
("Client")

Birth Date: _____/_____/_____
Month Day Year

I, the undersigned, on behalf of myself (and/or on behalf of Client) hereby authorize:

Individual

Name: _____

Phone Number: _____

Address: _____
Street

_____ _____ _____
City State Zip Code

Entity/Organization

Name: _____

Phone Number: _____

Attention: _____
Individual Name

Address: _____
Street

_____ _____ _____
City State Zip Code

To communicate with and disclose/release Client's confidential/protected health information to the following person(s) or class of persons (collectively "recipient(s)"):

Developmental Therapy Center, Inc. (DTC)
P.O. Box 33568, San Diego, CA 92163

The recipient(s) identified above is/are permitted to use the information disclosed for the following purposes (check all that apply):

☐ Continuing Medical Care ☐ Personal (i.e. at my request)

☐ Legal ☐ Insurance

☐ Other (please specify): Verification of Benefits

This authorization applies to the following information (check all that apply):

☐ All records and health information

☐ Only the following:

☐ Dates of treatment attendance ☐ Individual Family Service Plan (IFSP)

☐ Diagnosis ☐ Individualized Education Program (IEP)

☐ Test results ☐ Individual Program Plan (IPP)

☐ Treatment notes/records ☐ Billing Information

☐ Medical, Educational and/or Psychological/Psychiatric Reports

☐ Verbal or written communication between DTC and the identified recipient(s)

☐ Other (please specify) _____

NOTE: The records/information released as part of this authorization may contain references related to mental health, addiction, and HIV medical conditions. I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment

☐ Alcohol/drug treatment

☐ HIV test results

For the following date(s) of service:

☐ Any and all dates of service

☐ Only the following: From: _____ /_____ /_____ To: _____ /_____ /_____

Month Day Year Month Day Year

This authorization is valid for one (1) year from the date of signature, unless revoked or a different date is specified here: _____ /_____ /_____

Month Day Year

I understand I may revoke this authorization at any time, which revocation must be in writing, signed by me, and delivered to DTC, Attn: Privacy Officer, P.O. Box 33568, San Diego, CA 92163. I understand the revocation will be effective only when DTC actually receives it. I understand revocation will not be effective to the extent that DTC or others have already acted in reliance upon this authorization.

I understand if I have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. I hereby release disclosing party from any/all liability that may arise from the release of information to the recipient(s).

I understand this authorization is voluntary and I may refuse to sign this authorization. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon on my providing or refusing to provide this authorization.

I understand I may be responsible for payment of a reasonable cost-based processing fee. The fee covers clerical costs as well as any/all costs associated with copying of the information.

I understand I am entitled to a copy of this authorization upon my request.

INTENTIONALLY LEFT BLANK

(Signatures on Next Page)

By signing below, I acknowledge I have read and understand the Authorization for the Use and/or Disclosure of Protected Health Information and hereby authorize release of records/information to the recipient(s) named above. I also acknowledge I am responsible for all fees that may occur due to the records request.

Date: _____ /_____ /_____
Month Day Year

Name: _____

Signature: _____

Name of individual whose health information is to be released:

Name: _____

If you are signing as the individual's authorized representative:

Name: _____

Describe your Authority: _____

_____

If necessary:

Approval by Mental Health Provider Welfare and Institutions Code Section 5328(b)

Date: _____ /_____ /_____
Month Day Year

License No.: _____

Name: _____
Print

Signature: _____
Sign

Developmental Therapy Center

General Information, Policies and Procedures

Welcome to DTC! We are proud to provide the highest quality therapy for our clients and their families and look forward to working together towards goals designed to help each client achieve his or her maximum potential.

This document, along with any addenda attached hereto and incorporated by reference herein, contains general information as well as important policies and procedures that facilitate the success of DTC's programs. As the client's parent(s), guardian(s), conservator(s) or other responsible party(ies) (hereinafter "You"), it is very important you review and understand the general information contained herein and agree to abide by the policies and procedures set forth below.

The information, policies and/or procedures contained herein is/are subject to change, at DTC's sole discretion. If you have any questions about the information, policies and/or procedures contained herein, please contact your local DTC location.

1. The DTC Team

1.1. DTC Team. DTC uses a team approach when providing treatment services. While each client will have a designated therapist, other therapists may also provide support on occasion, which will provide the client an opportunity to learn from staff with different teaching styles. It is common for therapists will to cover for one another.

2. Your Role in Successful Therapy

2.1. Participation. Teaching you how to interact with the client to increase the client's skills directly and indirectly is an important part of a successful therapy program. **Your participation is essential**. DTC requests you participate in sessions, to the best of your ability, by observing, taking notes and engaging in activities with your therapist and the client. You will be taught how to participate and how to independently implement strategies to improve the client's skills.

2.1.1. Presence. Depending on the type of services being provided, your presence and/or participation may be required (*e.g.*, by the funding source or by DTC, at its sole discretion). In such circumstances the session may not be able to take place unless/until you are present/participating.

2.2. Communication. DTC expects you to communicate information that may impact the client's progress to your therapist. This includes, without limitation, medication changes, diet changes, health concerns and/or changes in the client's living situation. This information is necessary to ensure appropriate changes are made in the client's treatment, if necessary, and ensure the safety/well-being of both the client and DTC's staff.

2.3. Additional Considerations/Requirements for In-home Therapy Sessions

2.3.1. Professionalism and Mutual Respect. DTC is committed to maintaining a therapeutic environment free from all forms of hostility, harassment, discrimination, and other unprofessional conduct. DTC expects you will report to DTC any circumstances where a DTC staff member acts in an unprofessional or disrespectful matter at any time, especially while in your home. Conversely, DTC expects you will treat DTC staff in a professional and respectful matter at all times. If, in its sole discretion, DTC determines the environment is unsuitable (*e.g.*, due to hostility, harassment, discrimination, and other unprofessional conduct), DTC may discontinue services pending identification of an alternative arrangement.

2.3.2. Drug Free Workplace/Environment. DTC is also committed to maintaining a drug free workplace notwithstanding the location of its worksites. Accordingly, DTC expects you will not report to, or participate in, a session under the influence of drugs or alcohol (this includes the use of prescription or over-the-counter drugs that may impair the your ability to safely and effectively supervise or care for the client, or that affect the safety or wellbeing of others) and that you will not use drugs or alcohol during session times. If a DTC staff member reasonably determines you are under the influence of alcohol or drugs, and that your condition impairs your ability to safely and effectively supervise the client, or affects the safety or wellbeing of others, they will immediately discontinue services and may report the circumstances to the appropriate authorities, as required by law.

2.4. Additional Considerations

2.4.1. Drop-off/Presence. DTC's reserves the right, in its sole discretion, to ask/require you to remain on premises for the duration of the in-clinic group session (*e.g.*, if your funding source requires your presence, the client has a fragile medical history, the client demonstrates unsafe behaviors, *etc*.). If the client is participating in a session where your presence is not required, and you elect to leave the premises, you must be available by phone for the entire duration of the session in case of emergency and you will be required to execute a release of liability. If DTC cannot reach you during or after a session, the emergency contact for the client will be called/contacted. If the emergency contact cannot be reached, DTC will continue to supervise the client and call 911.

2.4.1.1. Late Pick-up Fee. If the client is participating in a session and you elect to leave the premises, you (or an authorized Responsible Party) must return to pick-up the client by the scheduled session end time. If you fail to do so, DTC reserves the right to charge you a childcare fee in the amount of $1.00 per minute for each minute after the scheduled session end time.

2.4.2. Cancellation/Tardiness. Your commitment to DTC's therapy is very important and client's attendance is especially critical to the success of therapy. In addition to the scheduling and attendance policies contained herein, the client will be removed from the schedule and placed on a waitlist if, among other things, they fail to attend four (4) therapy sessions (*i.e.,* no-show, cancel, extreme tardiness, *etc*.) in a two (2) month period. Also, the therapist assigned to work with the client will be re-assigned to work with another client, or relieved of their duties, twenty (20) minutes after the start of a thirty (30) minute session and forty-five (45) minutes late after the start of a sixty-minute (60) session.

2.4.3. Third Party Observation. DTC is collaborative in its approach to treatment; accordingly, third-parties (*e.g.*, district personnel, ABA therapists, other parents/caregivers, *etc*.) may observe from time to time. All visitors are required to sign a confidentiality form to protect clients who may be observed. If you would like to schedule a third-party observation, please contact your therapist.

2.5. Additional Considerations

2.5.1. Sibling Participation. Siblings are welcome and encouraged to participate in sessions when appropriate. The Responsible Party is responsible for the supervision/well-being of the sibling. Please note, if a sibling is disruptive to the program, the therapist may ask they not attend future sessions.

3. Scheduling and Cancelling Sessions

3.1. Scheduling. DTC's front office is available to ensure the best possible scheduling fit between clients and DTC's staff. All schedule changes must occur through the front office and may result in a staff change.

3.2. Cancellation/Rescheduling. If you need to cancel/reschedule a session, you must call DTC's front office at least twenty-four (24) hours prior to the scheduled session. You should not contact the therapist; DTC will notify them of the cancellation/rescheduling on your behalf. DTC requests cancellation/rescheduling be kept to a minimum. Excessive cancellation/rescheduling may result in staff changes, could impact client's progress and/or may jeopardize services.

3.2.1. Limitations**.** When you cancel a session, DTC is not required to make-up the session. Nonetheless, if a make-up session is scheduled, it must be completed within the contract period. Further, depending on the client's funding source, certain rules may apply as to when the make-up session may occur (*i.e*., the make-up session may need to be completed within the same week, month, or at the end of a 6-month or 12-month period, or the end of the fiscal year, sometimes make-up session may not occur on legal/school holidays, *etc*.).

3.2.2. Cancellation Fee. DTC understand there are times when you must miss a session due to emergency or other obligation; however, if you do not call to cancel/reschedule the session in advance, you may be preventing another client from obtaining much needed treatment. If a session is not cancelled/rescheduled at least twenty-four (24) hours in advance, DTC reserves the right to charge a cancellation fee. The first late, no show or cancel fee is $45.00, second is $90.00 and the third is $150.00.

3.2.3. Cancellation by DTC. On occasion DTC's staff may need to cancel a session due to unforeseen circumstances. In such situations, DTC will do its best to send substitute staff, based on availability, to conduct the session at the scheduled time. If substitute staff is not available, DTC will use its best efforts to schedule a make-up session as soon as practicable.

3.3. Tardiness/No Shows. It is important clients are ready to start the session at the scheduled start time. If you are running late for a session, please contact your local DTC office to let them know an estimated arrival time. While staff will wait up to twenty (20) minutes for a thirty (30) minute session, forty five (45) minutes for a sixty (60) minute session for you to arrive, staff may not be able complete the scheduled session duration if you are late. If necessary, DTC will do its best to reschedule your session. Again, please note excessive lateness/no shows may jeopardize services.

3.4. Illnesses. If a client is not well (*e.g.,* has symptoms such as fever, green mucous, diarrhea or vomiting, or symptoms of exposure to a communicable disease (*e.g.*, lice, HFMD, conjunctivitis, *etc*.), DTC expects the session will be cancelled in advance. As a general rule, if a client is too sick for school, he/she is too sick for therapy. DTC's staff cannot work with sick clients and clients should be free of all symptoms for twenty-four (24) hours before services are resumed. If a client arrives for a session and the client is not well, the session will be cancelled without 24 hour notice, accordingly you may be charged a fee.

4. Communication

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appropriate, formulate a proposed resolution, and contact you to discuss the findings and proposed resolution. If you are unsatisfied with the response/proposed solution, you can either continue to work with the clinical management team on a more informal level or lodge a formal complaint/grievance with the Clinical Operations Manager.

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7. Privacy

7.1. HIPAA. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires covered entities to have policies and procedures reflecting HIPAA's privacy mandates. DTC is committed to maintaining the privacy of client information and has developed administrative policies and procedures reflecting these privacy regulations. You will receive a separate "Health Insurance Portability and Accountability Act Privacy Use and Policies" that explains your privacy rights in detail and how DTC may use and disclose your protected health information.

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7.2. Release of Medical Information. DTC's clients will be asked to submit certain personal information, such as address and phone number, insurance information, medical history and treatment, *etc*. The principle purpose for requesting this information is to ensure accurate identification, continuity of care, and payment for such care. Under the authority of federal and/or state law, DTC is authorized to maintain this information. Furnishing all information requested by DTC is mandatory unless otherwise noted. Failure to provide such information may affect treatment and/or insurance benefits and coverage.

7.2.1. Authorization for Use and/or Disclosure. Except in circumstances where DTC is permitted or required by law to release information, DTC will obtain written consent/authorization to release of medical information, including specifically, information about treatment. You will need to sign an Authorization for the Use and/or Disclosure of Protected Health Information Form before DTC can/will discuss the client and their program with anyone (*e.g*., doctors, psychologists, teachers, *etc*.).

7.3. Confidentiality. Unless otherwise required by law (*e.g*., abuse reporting, legal process *etc*.), information in DTC possession regarding the client will remain strictly confidential. Case discussion, consultation, examination and treatment are confidential and will be conducted discreetly. All staff with access to confidential information are required to hold in complete confidence and not disclose, produce, publish, permit access to, or reveal any such confidential information.

7.4. Limitations. As indicated above, DTC respects and abides by all required privacy/confidentiality standards concerning client care and employs reasonable safeguards to protect against use and disclosure of protected health information. Nonetheless, by participating in therapy sessions, it is possible certain private/confidential information (*e.g*., client name, diagnosis, *etc*.), including specifically health information that may otherwise be protected from disclosure, may be exposed/disclosed, either implicitly or explicitly, to third-parties present in the clinic (*e.g*., other family members, friends, babysitter/nanny, housekeeper, *etc*.), other clients, parents, guardians, conservators or other responsible parties, teachers, participants and/or members of the general public. Unless otherwise instructed in writing, DTC staff will conduct therapy sessions

despite the presence of third-parties and you, on behalf of yourself and the client, understand and agree to absolve/discharge DTC from any and all liability relating to or arising from any disclosure (incidental, limited or otherwise).

7.5. Video/Audio Recording. You are not allowed to photograph, videotape or audiotape sessions at any time, regardless of setting, without prior written consent from DTC and the individual staff members being recorded in a form acceptable to DTC and in DTC sole discretion. This specifically includes recording or monitoring sessions using a security or hidden camera (*e.g.*, nanny cam, *etc.*), a movement/sound monitor (*e.g.*, AngelSense, or other similar technology), and/or other electronic wireless communications device (*e.g.*, smartphone, tablet, specialized mobile radio device, *etc.*).

8. Billing

8.1. Billing Questions. If you have any questions about billing (*e.g.*, deductibles, co-payments, co-insurance and/or any other fees), please contact your local DTC office administrator. You can also find the contact information for the Billing Department on your billing statement.

8.2. Billing Disputes**.** If you do not notify DTC, in writing, of any objection to the information reflected on any billing statement (including, without limitation, any error or unauthorized activity on your account(s)) within thirty (30) days, DTC will assume the billing statement is correct and you approve of the charges. You agree to waive any objection to the amount of, or basis for, any charge(s) so approved and acknowledge DTC will be relying upon your approval in electing to continue to render services.

8.3. Insurance. DTC may, as a courtesy, contact your insurance or other health care benefit plan, if any, to determine whether coverage exists for services under an applicable insurance or other health care benefit plan contract. If coverage exists, you agree and authorize DTC to submit claims for services rendered to the applicable insurance or other health care benefit plan. Notwithstanding any insurance coverage, you shall remain responsible for payment of any deductible, co-payment, co-insurance and/or any other fees applicable under the insurance or other health care benefit plan contract, which are due at the time of service. You agree to notify DTC of any change in insurance or other health care benefit plan coverage within twenty-four (24) hours of any such change.

9. Miscellaneous

9.1. Termination. Ideally, treatment ends when all parties agree treatment goals have been achieved. If at any time during the course of your treatment DTC determines it can no longer continue providing services, at its sole discretion, DTC will terminate treatment. DTC specifically reserves the right to terminate treatment for any reason, or no reason, at any time.

9.1.1. Transition/Coordination of Care. Prior to discontinuation of treatment, your therapist will discuss the client's future service needs, provide appropriate pre-termination services, suggest alternative service providers as appropriate, and, upon consent, take other reasonable steps to facilitate timely transfer of responsibility to another provider.

9.2. Informed Consent. DTC is committed to respecting clients rights and to educating clients and their families about both their rights and responsibilities, including, but not limited to, information about client's condition and treatment options, including, but not limited to, information regarding the nature and goals of the treatment program, the manner/method of treatment, qualifications and responsibilities of staff, typical times, days and location(s) of treatment, duration of treatment, the risks associated with treatment (including, specifically, the risk of noncompliance with treatment recommendations) and alternative methods of treatment. If you have any questions regarding these matters, please contact your therapist.

9.2.1. Ability to Provide Informed Consent. While the client is a minor, you will be able to provide informed consent on the client's behalf. However, when the client reaches eighteen (18) years of age, the client will have the right to control decisions relating to his or her own health care, unless someone else is granted the ability to make health care decisions on the client's behalf (*e.g.*, a conservator, surrogate,

attorney-in-fact, *etc*.) In order to avoid potential disruption in services, DTC requests you consider and plan for how health care decisions will be made when the client becomes an adult and discuss your options with DTC's staff well in advance of the date the client reaches eighteen (18) years of age. Please refer to DTC's Informed Consent Policy for Non-Conserved Adult Clients/Members for additional information.

9.3. Reports. Progress reports will be written periodically and your therapist will review this report with you. If you would like a copy of any of these reports, you can request them from your funding source (*e.g*., your Case/Service Coordinator). If you are unable to get a copy of the report, you may request a copy of the report from DTC using the procedure set forth below.

9.4. Requests for Copy of Client Files. Requests for a copy of the client's file, or portions of the client's file, may be made to your DTC front office administrator. Please be sure to include the specific records being sought when submitting your request. The requesting party will be required to pay a fee to defray the cost of copying (typically twenty-five cents ($0.25) per page), as well as additional reasonable clerical costs incurred in making the records available, before DTC will release the copies of the records to the requesting party.

9.5. Litigation. DTC reserves the right to postpone and/or terminate services when/if DTC determines, in its sole discretion, that highly contentious litigation (including specifically dissolution, custody and/or visitation litigation) is having a negative impact on the client's treatment and/or DTC staff. DTC asks/requires you refrain from discussing/involving DTC staff in these matters.

9.5.1. Custody/Visitation Orders. DTC strictly adheres to the terms set forth in any and all Court Orders, specifically including custody and/or visitation Orders. In circumstances where custody/visitation terms are unclear or in dispute, DTC will request you provide the applicable Order(s) for review. To avoid potential disruption to services, DTC requests you provide complete copies of all custody/visitation documentation upon request.

9.5.2. Involvement in Litigation/Fees. DTC and/or its employees may not serve as an expert witness with regard to services rendered in any litigation matter. Further, if DTC or any of its employees receive(s) a subpoena to testify as a fact witnesses in any litigation or are otherwise involved in any litigation-related proceedings, you will be required to pay DTC and/or the employee, for any and all time spent attending to such litigation at the then current hourly rate set forth in DTC then current private pay fee schedule.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY OF DTC's GENERAL INFORMATION, POLICIES AND PROCEDURES DOCUMENT. I FURTHER ACKNOWLEDGE I HAVE READ AND FAMILIARIZED MYSELF WITH THE INFORMATION, POLICIES AND PROCEDURES CONTAINED IN THIS DOCUMENT, AND UNDERSTAND AND AGREE TO ABIDE BY THESE POLICIES AND PROCEDURES. I ALSO ACKNOWLEDGE MY UNDERSTANDING THAT FAILURE TO COMPLY WITH THE POLICIES AND/OR PROCEDURES CONTAINED IN THE GENERAL INFORMATION AND POLICIES DOCUMENT, OR AS OTHERWISE COMMUNICATED BY DTC FROM TIME TO TIME, COULD RESULT IN TERMINATION OF SERVICES.

Client's Name: _____

Client Birth Date: _____ /_____ /_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Developmental Therapy Center

PARENT COPY-General Information, Policies and Procedures

Welcome to DTC! We are proud to provide the highest quality therapy for our clients and their families and look forward to working together towards goals designed to help each client achieve his or her maximum potential.

This document, along with any addenda attached hereto and incorporated by reference herein, contains general information as well as important policies and procedures that facilitate the success of DTC's programs. As the client's parent(s), guardian(s), conservator(s) or other responsible party(ies) (hereinafter "You"), it is very important you review and understand the general information contained herein and agree to abide by the policies and procedures set forth below.

The information, policies and/or procedures contained herein is/are subject to change, at DTC's sole discretion. If you have any questions about the information, policies and/or procedures contained herein, please contact your local DTC location.

1. The DTC Team

1.1. DTC Team. DTC uses a team approach when providing treatment services. While each client will have a designated therapist, other therapists may also provide support on occasion, which will provide the client an opportunity to learn from staff with different teaching styles. It is common for therapists will to cover for one another.

2. Your Role in Successful Therapy

2.1. Participation. Teaching you how to interact with the client to increase the client's skills directly and indirectly is an important part of a successful therapy program. **Your participation is essential**. DTC requests you participate in sessions, to the best of your ability, by observing, taking notes and engaging in activities with your therapist and the client. You will be taught how to participate and how to independently implement strategies to improve the client's skills.

2.1.1. Presence. Depending on the type of services being provided, your presence and/or participation may be required (*e.g.*, by the funding source or by DTC, at its sole discretion). In such circumstances the session may not be able to take place unless/until you are present/participating.

2.2. Communication. DTC expects you to communicate information that may impact the client's progress to your therapist. This includes, without limitation, medication changes, diet changes, health concerns and/or changes in the client's living situation. This information is necessary to ensure appropriate changes are made in the client's treatment, if necessary, and ensure the safety/well-being of both the client and DTC's staff.

2.3. Additional Considerations/Requirements for In-home Therapy Sessions

2.3.1. Professionalism and Mutual Respect. DTC is committed to maintaining a therapeutic environment free from all forms of hostility, harassment, discrimination, and other unprofessional conduct. DTC expects you will report to DTC any circumstances where a DTC staff member acts in an unprofessional or disrespectful matter at any time, especially while in your home. Conversely, DTC expects you will treat DTC staff in a professional and respectful matter at all times. If, in its sole discretion, DTC determines the environment is unsuitable (*e.g.*, due to hostility, harassment, discrimination, and other unprofessional conduct), DTC may discontinue services pending identification of an alternative arrangement.

2.3.2. Drug Free Workplace/Environment. DTC is also committed to maintaining a drug free workplace notwithstanding the location of its worksites. Accordingly, DTC expects you will not report to, or participate in, a session under the influence of drugs or alcohol (this includes the use of prescription or over-the-counter drugs that may impair the your ability to safely and effectively supervise or care for the client, or that affect the safety or wellbeing of others) and that you will not use drugs or alcohol during session times. If a DTC staff member reasonably determines you are under the influence of alcohol or drugs, and that your condition impairs your ability to safely and effectively supervise the client, or affects the safety or wellbeing of others, they will immediately discontinue services and may report the circumstances to the appropriate authorities, as required by law.

2.4. Additional Considerations

2.4.1. Drop-off/Presence. DTC's reserves the right, in its sole discretion, to ask/require you to remain on premises for the duration of the in-clinic group session (*e.g.*, if your funding source requires your presence, the client has a fragile medical history, the client demonstrates unsafe behaviors, *etc*.). If the client is participating in a session where your presence is not required, and you elect to leave the premises, you must be available by phone for the entire duration of the session in case of emergency and you will be required to execute a release of liability. If DTC cannot reach you during or after a session, the emergency contact for the client will be called/contacted. If the emergency contact cannot be reached, DTC will continue to supervise the client and call 911.

2.4.1.1. Late Pick-up Fee. If the client is participating in a session and you elect to leave the premises, you (or an authorized Responsible Party) must return to pick-up the client by the scheduled session end time. If you fail to do so, DTC reserves the right to charge you a childcare fee in the amount of $1.00 per minute for each minute after the scheduled session end time.

2.4.2. Cancellation/Tardiness. Your commitment to DTC's therapy is very important and client's attendance is especially critical to the success of therapy. In addition to the scheduling and attendance policies contained herein, the client will be removed from the schedule and placed on a waitlist if, among other things, they fail to attend four (4) therapy sessions (*i.e.,* no-show, cancel, extreme tardiness, *etc*.) in a two (2) month period. Also, the therapist assigned to work with the client will be re-assigned to work with another client, or relieved of their duties, twenty (20) minutes after the start of a thirty (30) minute session and forty-five (45) minutes late after the start of a sixty-minute (60) session.

2.4.3. Third Party Observation. DTC is collaborative in its approach to treatment; accordingly, third-parties (*e.g.*, district personnel, ABA therapists, other parents/caregivers, *etc*.) may observe from time to time. All visitors are required to sign a confidentiality form to protect clients who may be observed. If you would like to schedule a third-party observation, please contact your therapist.

2.5. Additional Considerations

2.5.1. Sibling Participation. Siblings are welcome and encouraged to participate in sessions when appropriate. The Responsible Party is responsible for the supervision/well-being of the sibling. Please note, if a sibling is disruptive to the program, the therapist may ask they not attend future sessions.

3. Scheduling and Cancelling Sessions

3.1. Scheduling. DTC's front office is available to ensure the best possible scheduling fit between clients and DTC's staff. All schedule changes must occur through the front office and may result in a staff change.

3.2. Cancellation/Rescheduling. If you need to cancel/reschedule a session, you must call DTC's front office at least twenty-four (24) hours prior to the scheduled session. You should not contact the therapist; DTC will notify them of the cancellation/rescheduling on your behalf. DTC requests cancellation/rescheduling be kept to a minimum. Excessive cancellation/rescheduling may result in staff changes, could impact client's progress and/or may jeopardize services.

3.2.1. Limitations**.** When you cancel a session, DTC is not required to make-up the session. Nonetheless, if a make-up session is scheduled, it must be completed within the contract period. Further, depending on the client's funding source, certain rules may apply as to when the make-up session may occur (*i.e*., the make-up session may need to be completed within the same week, month, or at the end of a 6-month or 12-month period, or the end of the fiscal year, sometimes make-up session may not occur on legal/school holidays, *etc*.).

3.2.2. Cancellation Fee. DTC understand there are times when you must miss a session due to emergency or other obligation; however, if you do not call to cancel/reschedule the session in advance, you may be preventing another client from obtaining much needed treatment. If a session is not cancelled/rescheduled at least twenty-four (24) hours in advance, DTC reserves the right to charge a cancellation fee. The first late, no show or cancel fee is $45.00, second is $90.00 and the third is $150.00.

3.2.3. Cancellation by DTC. On occasion DTC's staff may need to cancel a session due to unforeseen circumstances. In such situations, DTC will do its best to send substitute staff, based on availability, to conduct the session at the scheduled time. If substitute staff is not available, DTC will use its best efforts to schedule a make-up session as soon as practicable.

3.3. Tardiness/No Shows. It is important clients are ready to start the session at the scheduled start time. If you are running late for a session, please contact your local DTC office to let them know an estimated arrival time. While staff will wait up to twenty (20) minutes for a thirty (30) minute session, forty five (45) minutes for a sixty (60) minute session for you to arrive, staff may not be able complete the scheduled session duration if you are late. If necessary, DTC will do its best to reschedule your session. Again, please note excessive lateness/no shows may jeopardize services.

3.4. Illnesses. If a client is not well (*e.g.,* has symptoms such as fever, green mucous, diarrhea or vomiting, or symptoms of exposure to a communicable disease (*e.g.*, lice, HFMD, conjunctivitis, *etc*.), DTC expects the session will be cancelled in advance. As a general rule, if a client is too sick for school, he/she is too sick for therapy. DTC's staff cannot work with sick clients and clients should be free of all symptoms for twenty-four (24) hours before services are resumed. If a client arrives for a session and the client is not well, the session will be cancelled without 24 hour notice, accordingly you may be charged a fee.

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7.1. HIPAA. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires covered entities to have policies and procedures reflecting HIPAA's privacy mandates. DTC is committed to maintaining the privacy of client information and has developed administrative policies and procedures reflecting these privacy regulations. You will receive a separate "Health Insurance Portability and Accountability Act Privacy Use and Policies" that explains your privacy rights in detail and how DTC may use and disclose your protected health information.

7.1.1. Business Associates. While HIPAA establishes a foundation of protection for personal health information, there are certain exceptions which permit disclosure to avoid unnecessary interference with access to quality health care or with certain other important public benefits or national priorities. Specifically, HIPAA permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities. Most health care providers and health plans do not carry out all of their health care activities and functions by themselves. Instead, they often use the services of a variety of other persons or businesses. Accordingly, HIPAA allows covered providers and health plans to disclose protected health information to these "business associates" if the providers or plans obtain satisfactory assurances each "business associate" will use the information only for the purposes for which it was engaged by the covered entity, will safeguard the information from misuse, and will help the covered entity comply with some of the covered entity's duties under HIPAA. Rest assured that, as a covered entity, DTC takes great care to obtain satisfactory guarantees that its "business associates" will abide by and, to the extent required, comply with the requirements of HIPAA.

7.2. Release of Medical Information. DTC's clients will be asked to submit certain personal information, such as address and phone number, insurance information, medical history and treatment, *etc*. The principle purpose for requesting this information is to ensure accurate identification, continuity of care, and payment for such care. Under the authority of federal and/or state law, DTC is authorized to maintain this information. Furnishing all information requested by DTC is mandatory unless otherwise noted. Failure to provide such information may affect treatment and/or insurance benefits and coverage.

7.2.1. Authorization for Use and/or Disclosure. Except in circumstances where DTC is permitted or required by law to release information, DTC will obtain written consent/authorization to release of medical information, including specifically, information about treatment. You will need to sign an Authorization for the Use and/or Disclosure of Protected Health Information Form before DTC can/will discuss the client and their program with anyone (*e.g*., doctors, psychologists, teachers, *etc*.).

7.3. Confidentiality. Unless otherwise required by law (*e.g*., abuse reporting, legal process *etc*.), information in DTC possession regarding the client will remain strictly confidential. Case discussion, consultation, examination and treatment are confidential and will be conducted discreetly. All staff with access to confidential information are required to hold in complete confidence and not disclose, produce, publish, permit access to, or reveal any such confidential information.

7.4. Limitations. As indicated above, DTC respects and abides by all required privacy/confidentiality standards concerning client care and employs reasonable safeguards to protect against use and disclosure of protected health information. Nonetheless, by participating in therapy sessions, it is possible certain private/confidential information (*e.g*., client name, diagnosis, *etc*.), including specifically health information that may otherwise be protected from disclosure, may be exposed/disclosed, either implicitly or explicitly, to

third-parties present in the clinic (*e.g*., other family members, friends, babysitter/nanny, housekeeper, *etc*.), other clients, parents, guardians, conservators or other responsible parties, teachers, participants and/or members of the general public. Unless otherwise instructed in writing, DTC staff will conduct therapy sessions despite the presence of third-parties and you, on behalf of yourself and the client, understand and agree to absolve/discharge DTC from any and all liability relating to or arising from any disclosure (incidental, limited or otherwise).

7.5. Video/Audio Recording. You are not allowed to photograph, videotape or audiotape sessions at any time, regardless of setting, without prior written consent from DTC and the individual staff members being recorded in a form acceptable to DTC and in DTC sole discretion. This specifically includes recording or monitoring sessions using a security or hidden camera (*e.g*., nanny cam, *etc*.), a movement/sound monitor (*e.g*., AngelSense, or other similar technology), and/or other electronic wireless communications device (*e.g*., smartphone, tablet, specialized mobile radio device, *etc*.).

8. Billing

8.1. Billing Questions. If you have any questions about billing (*e.g*., deductibles, co-payments, co-insurance and/or any other fees), please contact your local DTC office administrator. You can also find the contact information for the Billing Department on your billing statement.

8.2. Billing Disputes**.** If you do not notify DTC, in writing, of any objection to the information reflected on any billing statement (including, without limitation, any error or unauthorized activity on your account(s)) within thirty (30) days, DTC will assume the billing statement is correct and you approve of the charges. You agree to waive any objection to the amount of, or basis for, any charge(s) so approved and acknowledge DTC will be relying upon your approval in electing to continue to render services.

8.3. Insurance. DTC may, as a courtesy, contact your insurance or other health care benefit plan, if any, to determine whether coverage exists for services under an applicable insurance or other health care benefit plan contract. If coverage exists, you agree and authorize DTC to submit claims for services rendered to the applicable insurance or other health care benefit plan. Notwithstanding any insurance coverage, you shall remain responsible for payment of any deductible, co-payment, co-insurance and/or any other fees applicable under the insurance or other health care benefit plan contract, which are due at the time of service. You agree to notify DTC of any change in insurance or other health care benefit plan coverage within twenty-four (24) hours of any such change.

9. Miscellaneous

9.1. Termination. Ideally, treatment ends when all parties agree treatment goals have been achieved. If at any time during the course of your treatment DTC determines it can no longer continue providing services, at its sole discretion, DTC will terminate treatment. DTC specifically reserves the right to terminate treatment for any reason, or no reason, at any time.

9.1.1. Transition/Coordination of Care. Prior to discontinuation of treatment, your therapist will discuss the client's future service needs, provide appropriate pre-termination services, suggest alternative service providers as appropriate, and, upon consent, take other reasonable steps to facilitate timely transfer of responsibility to another provider.

9.2. Informed Consent. DTC is committed to respecting clients rights and to educating clients and their families about both their rights and responsibilities, including, but not limited to, information about client's condition and treatment options, including, but not limited to, information regarding the nature and goals of the treatment program, the manner/method of treatment, qualifications and responsibilities of staff, typical times, days and location(s) of treatment, duration of treatment, the risks associated with treatment (including, specifically, the risk of noncompliance with treatment recommendations) and alternative methods of treatment. If you have any questions regarding these matters, please contact your therapist.

9.2.1. Ability to Provide Informed Consent. While the client is a minor, you will be able to provide informed consent on the client's behalf. However, when the client reaches eighteen (18) years of age, the client will have the right to control decisions relating to his or her own health care, unless someone else is granted the ability to make health care decisions on the client's behalf (*e.g*., a conservator, surrogate, attorney-in-fact, *etc*.) In order to avoid potential disruption in services, DTC requests you consider and plan for how health care decisions will be made when the client becomes an adult and discuss your options with DTC's staff well in advance of the date the client reaches eighteen (18) years of age. Please refer to DTC's Informed Consent Policy for Non-Conserved Adult Clients/Members for additional information.

9.3. Reports. Progress reports will be written periodically and your therapist will review this report with you. If you would like a copy of any of these reports, you can request them from your funding source (*e.g*., your Case/Service Coordinator). If you are unable to get a copy of the report, you may request a copy of the report from DTC using the procedure set forth below.

9.4. Requests for Copy of Client Files. Requests for a copy of the client's file, or portions of the client's file, may be made to your DTC front office administrator. Please be sure to include the specific records being sought when submitting your request. The requesting party will be required to pay a fee to defray the cost of copying (typically twenty-five cents ($0.25) per page), as well as additional reasonable clerical costs incurred in making the records available, before DTC will release the copies of the records to the requesting party.

9.5. Litigation. DTC reserves the right to postpone and/or terminate services when/if DTC determines, in its sole discretion, that highly contentious litigation (including specifically dissolution, custody and/or visitation litigation) is having a negative impact on the client's treatment and/or DTC staff. DTC asks/requires you refrain from discussing/involving DTC staff in these matters.

9.5.1. Custody/Visitation Orders. DTC strictly adheres to the terms set forth in any and all Court Orders, specifically including custody and/or visitation Orders. In circumstances where custody/visitation terms are unclear or in dispute, DTC will request you provide the applicable Order(s) for review. To avoid potential disruption to services, DTC requests you provide complete copies of all custody/visitation documentation upon request.

9.5.2. Involvement in Litigation/Fees. DTC and/or its employees may not serve as an expert witness with regard to services rendered in any litigation matter. Further, if DTC or any of its employees receive(s) a subpoena to testify as a fact witnesses in any litigation or are otherwise involved in any litigation-related proceedings, you will be required to pay DTC and/or the employee, for any and all time spent attending to such litigation at the then current hourly rate set forth in DTC then current private pay fee schedule.

Developmental Therapy Center

Notice of Privacy Practices

This notice describes how medical information about clients (hereinafter "you") may be used and disclosed and how you can get access to this information.

Please review this notice carefully.

1. Summary of Rights and Obligations Concerning Health Information

DTC is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law, as well as by ethics of the licensed health professions. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by [name of practice].

Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- Plan your care and treatment;
- Provide treatment by us or others;
- Communicate with other providers such as referring physicians;
- Receive payment from you, your health plan, or your health insurer;
- Make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- Make you aware of services and treatments that may be of interest to you; and
- Comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.
You have certain rights to your health information. You have the right to:

- Ensure the accuracy of your health record;
- Request confidential communications between you and your physician and request limits on the use and disclosure of your health information; and
- Request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- Maintain the privacy of your health information;
- Provide you with notice, such as this Notice of Privacy Practices, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of our most current Notice of Privacy Practices;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain.
Should our information practices change, a revised Notice of Privacy Practices will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law.

We will not use or disclose your health information without your authorization, except as described in our most current Notice of Privacy Practices.

In the following document, we explain our privacy practices and your rights to your health information in more detail.

If you have limited proficiency in English, you may request a Notice of Privacy Practices in the language you are most familiar with.

2. We May Use or Disclose Your Medical Information In The Following Ways:

Treatment. We may use and disclose your medical information to provide you with medical treatment or services. For example, we may use your health information to write a prescription or to prescribe a course of treatment. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

Payment. We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

Health Care Operations. We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Business Associates. DTC sometimes contracts with third-party business associates for services. Examples include answering services, transcriptionists, billing services, consultants, and legal counsel. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require our business associates to appropriately safeguard your information.

Appointment Reminders. We may use and disclose Information in your medical record to contact you as a reminder that you have an appointment. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.

Treatment Options. We may use and disclose your health information in order to inform you of alternative treatments.

Release to Family/Friends. Our health professionals, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object

to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Health-Related Benefits and Services. We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you. In face- to-face communications, such as appointments with your physician, we may tell you about other products and services that may be of interest you.

Newsletters and Other Communications. We may use your personal information in order to communicate to you via newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Disaster Relief. We may disclose your health information in disaster relief situations where disaster relief organizations seek your health information to coordinate your care, or notify family and friends of your location and condition. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Marketing. In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may provide you with promotional gifts of nominal value. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

Fundraising. We may contact you as part of a fundraising effort relating to the practice.

Public Health Activities. We may disclose medical information about you for public health activities. These activities generally include the following:

- Licensing and certification carried out by public health authorities;
- Prevention or control of disease, injury, or disability;
- Reports of births and deaths;
- Reports of child abuse or neglect;
- Notifications to people who may have been exposed to a disease or may be at
- Risk for contracting or spreading a disease or condition;
- Organ or tissue donation; and
- Notifications to appropriate government authorities if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will make this disclosure when required by law, or if you agree to the disclosure, or when authorized by law and in our professional judgment disclosure is required to prevent serious harm.

Funeral Directors. We may disclose health information to funeral directors so that they may carry out their duties.

Food and Drug Administration (FDA). We may disclose to the FDA and other regulatory agencies of the federal and state government health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing monitoring information to enable product recalls, repairs, or replacement.

Psychotherapy Notes. Under most circumstances, without your written authorization we may not disclose the notes a mental health professional took during a counseling session. However, we may disclose such notes for treatment and payment purposes, for state and federal oversight of the mental health professional, for the purposes of medical examiners and coroners, to avert a serious threat to health or safety, or as otherwise authorized by law.

Research. We may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.

Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement. We may release your health information:

- In response to a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law;
- To identify or locate a suspect, fugitive, material witness, or similar person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct;
- To coroners or medical examiners;
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime;
- To authorized federal officials for intelligence, counterintelligence, and other
- National security authorized by law; and
- To authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

De-identified Information. We may use your health information to create "de-identified" information or we may disclose your information to a business associate so that the business associate can create de-identified information on our behalf. When we "de-identify" health information, we remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.

Personal Representative. If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

Limited Data Set. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research, public health, and health care operations. We may not disseminate the limited data set unless we enter into a data use agreement with the recipient in which the recipient agrees to limit the use of that data set to the purposes for which it was provided, ensure the security of the data, and not identify the information or use it to contact any individual.

3. Authorization for Other Uses of Medical Information

Uses of medical information not covered by our most current Notice of Privacy Practices or the laws that apply to us will be made only with your written **authorization**.

If you provide us with authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization or, if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim or the insurance coverage itself. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care that we provided to you.

4. Your Health Information Rights

You have the following rights regarding medical information we gather about you:

Right to Obtain a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your medical information, we may charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program.

We may deny your request to inspect and copy in certain limited circumstances.

If you are denied access to medical information, you may request that the denial be reviewed. A licensed healthcare professional who was not directly involved in the denial of your request will conduct the review. We will comply with the outcome of the review.

If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information.

To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for DTC;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement.

We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- Disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- Disclosures made pursuant to your authorization;
- Disclosures made to create a limited data set;
- Disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request

should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by e-mail). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. If you paid out-of-pocket for a specific item or service, you have the right to request that medical information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we are required to honor that request.

You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care.
Except as noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us:

- What information you want to limit;
- Whether you want to limit our use, disclosure, or both; and
- To whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail.

To request confidential communications, you must make your request in writing to our privacy officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach.

"Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- A brief description of the breach, including the date of the breach and the date of its discovery, if known;
- A description of the type of Unsecured Protected Health Information involved in the breach;
- Steps you should take to protect yourself from potential harm resulting from the breach;
- A brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- Contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred. See the Office for Civil Rights website, www.hhs.gov/ocr/hipaa/ for more information.

You will not be penalized for filing a complaint.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY OF DTC'S NOTICE OF PRIVACY PRACTICES. I FURTHER ACKNOWLEDGE I HAVE READ AND FAMILIARIZED MYSELF WITH THE INFORMATION, POLICIES AND PROCEDURES CONTAINED IN THIS DOCUMENT.

Client's Name: _____ Birth Date: _____ /_____ /_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Developmental Therapy Center

Client Rights

You have the right to:

1. Receive treatment/care without regard to race, color, culture, gender (including gender identity and gender expression), religion, marital status, registered domestic partner status, age, national origin or ancestry, physical or mental disability, medical condition, genetic information, sexual orientation, military and veteran status, economic status or educational background.

2. Receive treatment/care in a safe setting free from abuse, neglect, retaliation, humiliation, restraint, seclusion, any means of coercion, and/or exploitation (financial or otherwise). This includes the right to access protective and/or advocacy services and notify government agencies of abuse or neglect (or suspected abuse or neglect).

3. Know the name, professional credential(s), and professional relationship(s) of the individual(s) primarily responsible for coordinating your treatment/care.

4. Receive effective communication, in a language you understand, including information about your status, diagnosis, prognosis, course of treatment/care, prospects for recovery, and outcomes of treatment/care (including unanticipated outcomes).

5. Participate in the development and implementation of your plan of treatment/care, including the right to participate in discussions concerning ethical questions that arise in the course of your treatment/care.

6. Make decisions regarding your treatment/care, and receive as much information about any proposed treatment/care or procedure as you may need in order to give informed consent or to refuse a course of treatment/care. Except in emergencies, this information shall include a description of the treatment/care, the significant risks involved, alternate courses of treatment/care or non-treatment/non-care and the risks involved in each and the name of the person who will carry out the treatment/care.

7. Request, refuse or leave treatment/care, to the extent permitted by law. However this does not give you the right to demand inappropriate or unnecessary treatment/care.

8. Be fully informed if you are being asked to participate in any clinical research, including the right to refuse to participate in any such research project(s).

9. Reasonable responses to any reasonable requests made for treatment/care.

10. Privacy and confidentiality pertaining to your condition, diagnosis and/or treatment/care, including any case discussion, consultation, examination and records related thereto. This includes the right to informed consent or expression of choice regarding release and requests of information (you will receive a separate “Notice of Privacy Practices” that explains your legal rights related to privacy in more detail, and how and when DTC may use and disclose your protected health information).

11. Reasonable continuity of treatment/care, and to know, in advance, the time and location of appointments, as well as the identity of the person(s) providing the treatment/care.

12. Access to referrals for self-help, advocacy, legal, etc. For additional information, please see DTC Referral Policy.

13. Be informed of the rules, policies and/or procedures that apply to your conduct as a DTC client.

14. Receive and examine an explanation of any billing related to treatment/care, regardless of the source of payment.

15. File a grievance and/or request an ethics consultation if conflict between you and DTC' staff arises regarding treatment/care decisions, and this conflict cannot be adequately resolved. A grievance regarding your treatment/care at DTC can be submitted in writing to grievance@acesaba.zendesk.com or by calling (800) 515-5016. For additional information, please see DTC Client Grievance Policy.

16. File a grievance or complaint with the applicable professional credentialing or licensing board associated with DTC or any staff member working for DTC, including, but not limited to the Board of Occupational Therapy, and/ or Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board.

17. File a complaint with the state Department of Developmental Services or Department of Health Care Services regardless of whether you use the DTC grievance process. The state Department of Developmental Services phone number is (916) 654-1690 and the address is P.O. Box 944202, Sacramento, CA 94244-2020. The state Department of Health Care Services' phone number is (800) 896-4042 and address is P.O. Box 997413, MS 0015, Sacramento, CA 95899-7413.

18. Review all the above listed rights annually, and to receive a copy of these rights at any time.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THE CLIENT RIGHTS DOCUMENT.

Client's Name: _____ Birth Date: _____ /_____ /_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____ /_____/_____
Month Day Year