Creating Brighter Futures

4201 Varsity Drive
Suite B & C
Ann Arbor, MI 48108
(P) 734-926-0740
(F) 734-369-8851

Client Intake Form

Basic Client Information

Client Name: Nickname:
Date of Birth: Age: Gender: ☐ Male ☐ Female
Address:
City/State: Zip Code: County:

Please indicate which service(s) you are interested in at CBF (age range indicated in parentheses):

☐ Early Intervention(2-8) ☐ Juniors/Adolescent(8-18)

☐ Speech Therapy(2-18) ☐ PEERS Social Skills(13-18)

Family Information

Parent/Guardian Name: Occupation:
Phone Number: Email:
Address:
City/State: Zip Code: County:

Parent/Guardian Name: Occupation:
Phone Number: Email:
Address:
City/State: Zip Code: County:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Others Living in the Child's Home:

Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

Diagnostic Information

Please provide a copy of all diagnostic evaluation reports.

Diagnosis: Date of Diagnosis:
Who provided this diagnosis?

Diagnosis: Date of Diagnosis:
Who provided this diagnosis?

Is there a family history of developmental and/or speech delay? ☐ Yes ☐ No
If yes, please explain:

Medical History

Physician Name: Phone Number:
Practice Name/Location: Fax Number:

Please check all that apply:

☐ ADD/ADHD
☐ Allergies
☐ Asthma
☐ Ear Infections
☐ Feeding/Swallowing Difficulties
☐ Hearing Difficulties
☐ Physical Trauma
☐ Seizures
☐ Skin Problems
☐ Vision Problems
☐ Wears Glasses/Contacts
☐ Wears Hearing Aid(s)

Other illnesses/conditions?
Any hospitalizations/surgeries? Explain

Please list all current medications and dosages:

Medication	Purpose	Dosage	Date Started

Please list any allergies your child has:

Allergies	Reaction	Treatment Protocol

If your child is on a special diet, please explain:

Has your child had their hearing tested? ☐ Yes ☐ No Date of Hearing Test:

Who completed the hearing test?

Results: ☐ Normal ☐ Abnormal ☐ Inconclusive

Has your child had their vision tested? ☐ Yes ☐ No Date of Vision Test:

Who completed the vision test?

Results: ☐ Normal ☐ Abnormal ☐ Inconclusive

Birth & Developmental History

Length of Pregnancy: Length of Labor:

Type of Delivery: APGAR Score:

Please list any complications during pregnancy or delivery:

At approximately what age did your child achieve these developmental milestones?

Sat Up Unassisted: Crawl: Walk: Run:

Dress Themselves: Eat w/ Utensils: Drink from a cup:

Bladder Trained: Bowel Trained:

Babbled: Said 1st Words: Spoke in phrases:

Would you say that your child is clumsy (i.e. trips/falls often)? ☐ Yes ☐ No

Does your child have trouble with fine motor skills? ☐ Yes ☐ No

Has there been any regression in developmental skills? ☐ Yes ☐ No

If Yes, please explain:

Speech & Language

What is your child's primary method of communicating?

☐ Gestures ☐ Sentences

☐ Sign Language ☐ Picture Exchange

☐ Single Words ☐ Communication Device

☐ Short Phrases ☐ Other

How does your child make his/her needs known?

How much of your child's language do you understand?

☐ 10% of less ☐ 11-25% ☐ 26-50% ☐ 51-75% ☐ 76-95% ☐ 96-100%

How much of your child's language do unfamiliar listeners understand?

☐ 10% of less ☐ 11-25% ☐ 26-50% ☐ 51-75% ☐ 76-95% ☐ 96-100%

Speech & Language cont.

Does your child:

Respond to his/her name?	☐ Yes ☐ No
Follow simple directions?	☐ Yes ☐ No
Label familiar objects?	☐ Yes ☐ No
Point to objects when named?	☐ Yes ☐ No
Repeat others' expressions?	☐ Yes ☐ No
Use at least 50 words consistently?	☐ Yes ☐ No
Ask Questions?	☐ Yes ☐ No
Answer Questions?	☐ Yes ☐ No

Are there languages other than English spoken in the home? ☐ Yes ☐ No

If yes, which language(s)?

Is this your child's primary language?	☐ Yes ☐ No
Does your child speak the language?	☐ Yes ☐ No
Does your child understand the language?	☐ Yes ☐ No

Behavioral History

Please list any challenging behaviors your child currently engages in:

Behavior	How often does it occur?	Is there anything that you know will trigger the behavior?	Is there anything you know that will make your child stop engaging in the behavior?

Please list any self-stimulatory behaviors your child currently engages in:

Behavior	How often does it occur?	Is there anything that you know will trigger the behavior?	Is there anything you know that will make your child stop engaging in the behavior?

Education & Therapy History

Please indicate all past/current educational and therapy providers. Attach any recent evaluations.

Education Provider

Name of School:
Classroom Type:
Teachers Name: Grade:
Address:
Phone Number:
Current Schedule:
Does your child have a 504/IEP? ☐ Yes ☐ No

Behavioral Therapy Provider

Provider Name:
Contact Name: Phone Number:
Dates of Service:
Schedule:
Reason for discontinuing:

Speech Therapy Provider

Provider Name:
Contact Name: Phone Number:
Dates of Service:
Schedule:
Reason for discontinuing:

Occupational Therapy Provider

Provider Name:
Contact Name: Phone Number:
Dates of Service:
Schedule:
Reason for discontinuing:

Physical Therapy Provider

Provider Name:
Contact Name: Phone Number:
Dates of Service:
Schedule:
Reason for discontinuing:

Other Therapy Provider

Provider Name:
Contact Name: Phone Number:
Dates of Service:
Schedule:
Reason for discontinuing:

Caregiver Input

Please indicate the most liked and disliked items in each category below:

	Likes	Dislikes
Food		
Toys/Objects		
Activities @ Home		
Activities/Outings in the Community		
Other		

What are your child's strengths?

What are your child's weaknesses?

Does your child participate in any extra curricular activities? If so, please list them:

Please list your top three immediate/short term goals for your child:

1.	
2.	
3.	

Please list your top three long term goals for your child:

1.	
2.	
3.	

Responsible Party Information

Please fill out the following information regarding the person who is financially responsible for the client attending Creating Brighter Futures

Guarantor's Name: DOB:
Social Security Number: Relation to Client:
Address:
Phone Number:
Email Address:
Employer:

Would you like your invoices to be mailed or emailed to you? ☐ Mail ☐ E-Mail

_____ _____
Signature of the Individual assuming Financial Responsibility Date

Insurance Information

Please provide a copy of both sides of all applicable insurance cards prior to the start of initiating services at Creating Brighter Futures.

Primary Insurance:
Subscriber's Name: DOB:
Policy ID #: Group #:
Relation to Client:

Secondary Insurance:
Subscriber's Name: DOB:
Policy ID #: Group #:
Relation to Client:

Printed Name of Person Completing Form: _____

Signature of Person Completing Form: _____

Date Completed: _____

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Client Attendance Policy (CAP)

Creating Brighter Futures takes pride in hiring and providing ongoing training to all staff in order to provide our clients with the highest quality of service. When your child is unable to come to the center for the day (or any portion thereof), Creating Brighter Futures is still responsible for paying for the staff that was assigned to work with your child. From a business perspective, we can only maintain a portion of this expense throughout the year.

The number of hours of excused absences with no financial penalty per calendar year is determined based on the number of hours your child is scheduled to receive each week.

Number of Scheduled Hours per Week	Number of Excused Hours per Year
6	12
10	20
15	30
20	40
30	60

- ★ CAP time will be pro-rated for clients starting mid-year.
- ★ Unused time WILL NOT be carried over into the following year.
- ★ CAP time will be tracked in 15-minute increments
- ★ CAP time will be used to account for late arrivals and early pick-ups from therapy.
- ★ Absences are not deducted from CAP time if your BCBA is notified 30 days in advance.
- ★ Once all CAP time has been exhausted, the financially responsible party will be charged based on the following scale:

Time	Charge
15 minutes	$10
30 minutes	$25
60 minutes	$50
½ day	$50
Full day	$100

Minimizing the need for CAP time by notifying your BCBA in writing when your child will not be at the center!

By signing below, I confirm that I understand and accept the client attendance policy.

Signature of Financially Responsible Person _____ Date _____

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Client Sick Policy

In an effort to maintain the learning experience and keep the Creating Brighter Futures staff and clients healthy, Creating Brighter Futures has put the following guidelines in place. Please keep your child home in they are experiencing any of the following:

- *Fever of 100° or greater* (children may return when they have been fever-free for 24 hours WITHOUT MEDICINE)
- *Irritability, lethargy, or persistent crying* that would interfere with the child's ability to learn
- *Excessive coughing or difficulty breathing*
- *Upper respiratory illness* (e.g. bronchitis or influenza)
- *Diarrhea*
- *Bloody stools or stools containing mucus* (these could be signs of a viral or bacterial infection)
- *Vomiting* (please keep your child home until they have reached 24 hours without vomiting)
- *Undiagnosed rash*
- *Chicken pox* (children are no longer contagious once all of the sores have dried and crusted over)
- *Impetigo* (children are no longer contagious after 24 hours of antibiotics)
- *Scabies* (until treated)
- *Bacterial conjunctivitis (pink eye) or yellow discharge from the eye* (please keep child at home if a doctor considers contagious)
- *Strep throat*
- *Mouth sores*
- *Moderate to heavy drainage* (from ears, mouth, nose, or eyes- clear or discolored)
- *Head lice* (children can return after they have been thoroughly treated)
- *Cuts or open sores* (oozing or pus-filled)
- *Ringworm* (please keep at home until treatment has begun)

Your child may return to Creating Brighter Futures once they have been symptom free for 24 hours. If a child experiences any of these illnesses or symptoms during the therapy day, parents will be contacted to pick their child up in a timely manner. The sick child may return to Creating Brighter Futures no sooner than 24 hours after they were initially sent home UNLESS a physician provides written documentation.

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Emergency Contact & Permission to Pick up Client

Please provide a list of Emergency Contacts, in the order you would like us to contact in the case of an emergency.

Name: Relationship to Client:
Phone #: Alt Phone #:
Is this person authorized to pick up the client? ☐ Yes ☐ No

Name: Relationship to Client:
Phone #: Alt Phone #:
Is this person authorized to pick up the client? ☐ Yes ☐ No

Name: Relationship to Client:
Phone #: Alt Phone #:
Is this person authorized to pick up the client? ☐ Yes ☐ No

Name: Relationship to Client:
Phone #: Alt Phone #:
Is this person authorized to pick up the client? ☐ Yes ☐ No

Name: Relationship to Client:
Phone #: Alt Phone #:
Is this person authorized to pick up the client? ☐ Yes ☐ No

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Authorization to Release Client Information

Clients Name: DOB:

As the parent/guardian of the child listed above, I authorize Representatives at Creating Brighter Futures to release and/or share information (verbal, written, or video) of the above-named client to the following providers:

School Provider

Name of Provider
Address:
Phone Number: Fax Number:

Primary Care Physician

Name of Provider
Address:
Phone Number: Fax Number:

Other Therapy Provider

Name of Provider
Address:
Phone Number: Fax Number:

As the parent/guardian ("Parent") of , a minor child with autism ("Minor"), authorizes the release of Minor's personal health information for purposes related to Minor's treatment at Creating Brighter Futures ("CBF") for payment for the services Minor has received. CBF is specifically authorized to: (1) release any information necessary for direct insurance billing and invoice generation, (2) release any information necessary to insurance carriers regarding Minor's treatment/services Minor has received, (3) process insurance claims generated in the course of Minor's treatment/provision of services to Minor, and (4) release information when, in CBF's sole discretion, such release is necessary to facilitate the provision of treatment/services to Minor.

_____
Printed Name of Parent/Guardian

_____ _____
Signature of Parent/Guardian Date

I understand that this authorization can be revoked in writing at any time.

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Financial Policy

As professional courtesy to our patients we make every effort to inform you about the cost of your therapy prior to your treatment. Despite our best efforts, we cannot always anticipate every cost, or how much your insurance plan will reimburse. In order to diminish unforeseen expenses, we ask that you, too, become informed about your insurance coverage. Together, we can achieve better results.

Payment is expected on the day that services are rendered. If you have insurance, we will be happy to submit your claim on your behalf. If your coverage can be verified, then we will collect any deductibles, co-payments, or co-insurance after the insurance has processed the claim and provided CBF with a specific amount owed by the patient. If your coverage cannot be verified prior to your treatment, we will collect payment in full at the time of your service and provide you with the forms to submit to your insurance company for reimbursement. (*Please note that reimbursement from your insurance company is not guaranteed; any unpaid claims are the patient's / guarantor's responsibility*). Clients paying for services through insurance benefits agree to pay co-pays and deductibles to Creating Brighter Futures in the following way:

- Once a month the CBF Office Manager will provide an invoice of all previously processed service claims by the insurance company, which include a client portion. Payment will be collected in the form of cash, check, or credit/debit card.
- If balances cannot be paid in full within 30 days, please see the Office Manager to set up a payment plan.

When it is time for a client to leave our program, any unpaid balances must be paid in full on or before the client's last date of service, unless a payment plan has been arranged. Any balances that are processed after the last day of service will be charged to the card that has been provided to us in this financial/cancellation policy.

As the parent/guardian ("Parent") of , a minor child with autism ("Minor"), I understand and agree that the treatment and services provided by Creating Brighter Futures ("CBF") create a financial responsibility on the part of the Parent. Parent agrees to pay and guarantees payment in full of any and all charges for treatment or services provided or to be provided to Minor by CBF and by other providers or professional entities that may provided services to Minor through CBF. CBF may bill Parent's insurance carrier on Parent's behalf; however, Parent is ultimately responsible for the payment of all charges. Parent authorizes and directs his/her insurance company to issue payment for any applicable medical benefit directly to CBF. Parent understands and agrees that he/she is responsible for any amount not covered by insurance.

Signature of Financially Responsible Person _____ Date _____

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Authorization for Automatic Health Care Payment by Credit Card

I authorize Creating Brighter Futures to keep my signature on file and to charge my account for charges that are deemed Patient Responsibility.

This authorization extends to all recurring charges, co-payments, or deductibles incurred at the time of service unless another method of payment is provided at the time of service.

This authorization also applies to any missed appointments as described in the Client Attendance Policy (CAP). If the applicable fee cannot be paid by other means at the next scheduled appointment, your credit card will be charged the appropriate amount per stated policy when the monthly invoices are processed.

This authorization shall be valid for one year, or until services are concluded, or with written notice to Creating Brighter Futures.

Client's Name: Client's DOB:
Cardholder's Name:
Cardholder's Billing Address:
Credit Card Number:
3-Digit CVC (back of card)
Expiration Date:

_____ _____
Signature of Cardholder Date Signed

*Please note: Any charges that are declined will result in a $25.00 fee for processing. Cards whose expiration dates occur during the course of the year will be subject to the above fee, if not updated within 10 days of notification of expiration.

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Informed Consent for Treatment of Minor & Waiver of Liability

As the parent/guardian ("Parent") of , a minor child with autism ("Minor"), give my consent for Creating Brighter Futures ("CBF") to provide treatment and behavioral analytic services to Minor. Parent specifically authorizes CBF to provide services to Minor with or without the supervision of the Parent.

Parent understands that students or other trainees may participate in the provision of supervised treatment or services to Minor. Parents are aware that consultants, independent contractors and professionals other than CBF may directly provide or be involved with the provision of services to Minor and Parent acknowledges that such individuals or entities are not Agents or Employees of CBF.

Parents agree that he/she will provide CBF with up-to-date emergency contact information. In the event of an emergency, CBF shall, at its sole discretion, contact emergency medical personnel or seek other emergency assistance, as dictated by the circumstances. Parent agrees that CBF, nor any individual employed by or contracted by CBF, shall be held liable by Parent or Minor for any reasonable action taken in response to an emergency situation.

Signature of Parent/Guardian

Date

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Confidentiality Act/Abuse Reporting Protocol

Client Name: DOB:

I understand that all information related to the above-named client's assessment and treatment must be handled with strict confidentiality. No information related to the Client, either verbal or written, will be released to other agencies or individuals without the express written consent of the Client's legal guardian (minor), or the consent of any Client of legal age.

By law, the rules of confidentiality do not hold under the following conditions:

- If abuse or neglect of a minor or disabled person is reported or suspected, the professional involved is required by law to report it to the Department of Children & Families for investigation.
- If, during the course of service, an individual receives information that someone's life is in danger, that professional has the duty to warn the potential victim as well as the authorities as is fitting to the circumstances.
- If Creating Brighter Futures' records, any sub-contractor records, or staff testimony are subpoenaed by a court order, Creating Brighter Futures is required by law to produce the requested information, including an appearance in a court of law, if necessary, to answer any questions regarding the Client.

_____ _____

Signature of Parent/Guardian Date

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HIPAA Notice of Privacy Practices

In order to protect the privacy of your health information and your child's health information, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted. HIPAA protections apply to *individually identifiable* "protected health information" that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify the individual (hereinafter referred to as "protected health information"). This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

I. **Uses and disclosures for treatment, payment, and health care operations**
Creating Brighter Futures may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, the following definitions apply:

- **PHI**: Information in your health record that could identify you.
- **Treatment**: Actions we take to provide, coordinate, or manage your health care and other services related to your health care. An example of treatment is when we consult with another health care provider, such as your family physician or another psychologist.
- **Payment**: Actions to obtain reimbursement for your health care.
- **Health care operations**: Activities that relate to the performance and operation of CREATING BRIGHTER FUTURES, such as quality assessment, business related matters, audits and administrative services, case management, and care coordination.
- **Use**: Activities within CREATING BRIGHTER FUTURES such as sharing, employing, using, and analyzing information that identifies you or your child.
- **Disclosure**: Activities outside of CREATING BRIGHTER FUTURES, such as sharing, employing, using, and analyzing information that identifies you or your child.
- **Authorization**: Your written permission to disclose confidential mental-health information. This requires your signature on a specific legally required form.

II. Other uses and disclosures requiring authorization

CREATING BRIGHTER FUTURES may use or disclose PHI for purposes outside of treatment, payment, or healthcare operations, when your appropriate authorization is obtained. In such cases, we will obtain an authorization from you before releasing this information. We will also need your authorization before releasing your child's program information. This also includes assessment data and the associated written report.

You may revoke all such authorizations (PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that we have relied on that authorization for treatment and/or assessment or if the authorization was obtained as a condition of obtaining insurance coverage; the law provides the insurer the right to contest the claim under the policy.

III. Uses and disclosures without authorization

- Child Abuse and Adult/Domestic Abuse
- Health Oversight Activities: If CREATING BRIGHTER FUTURES receives a subpoena from a regulation board, CREATING BRIGHTER FUTURES must disclose any PHI requested by the board.
- Judicial and Administrative Proceedings: If you are involved in court proceedings, and we receive a court order for your private information, CREATING BRIGHTER FUTURES must provide all court ordered information. We will attempt to inform you first. This also applies to situations when disclosure is necessary to arrange for legal services to enforce or defend CREATING BRIGHTER FUTURES's legal rights.
- Serious Threat To Health or Safety of Self or Others
- National Security

Patient Rights: IV. Patient's Rights and CREATING BRIGHTER FUTURES's Duties

A. Patient's Rights

- **Right to request restrictions**: You have the right to request restrictions on certain uses and disclosures of PHI. However, CREATING BRIGHTER FUTURES is not required to agree to a restriction you request.
- **Right to receive confidential communications by alternative means and at alternative locations**: You have the right to request and receive confidential communications of PHI by alternative means at alternative locations. For example, you can request that your bills be sent to a location other than your home address.
- **Right to inspect and copy**: You have the right to inspect and/or obtain a copy of the PHI as long as the PHI is maintained in the record. CREATING BRIGHTER FUTURES may deny your access to PHI under certain circumstances, but in some

cases, you may have this decision reviewed. You have the right to inspect and/or obtain a copy of your child's program, unless we believe the disclosure of the record will be injurious to your health. On your request, CREATING BRIGHTER FUTURES will discuss with you the details of the request and denial process.

- **Right to amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Creating Brighter Futures may deny your request. At your request, we will discuss with you the details of the amendment process.
- **Right to an accounting**: You generally have the right to receive an accounting of disclosures of PHI. Please ask if you would like CREATING BRIGHTER FUTURES to discuss the details of the accounting process.
- **To a paper copy**: A copy of this HIPAA notice is posted in the office for your review. If would like to receive a paper copy, please inform us.

B. CREATING BRIGHTER FUTURES Duties

- CREATING BRIGHTER FUTURES is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.
- CREATING BRIGHTER FUTURES reserves the right to change the privacy policies and practices described in this Notice. Unless CREATING BRIGHTER FUTURES notifies you of such changes, however, we are required to abide by the terms currently in effect.
- If CREATING BRIGHTER FUTURES revises our policies and procedures, we will notify you at your next scheduled appointment unless you request notification by mail.

C. Complaints

If you are concerned that CREATING BRIGHTER FUTURES has violated your privacy rights, or you disagree with a decision we made about access to your records, please discuss it with us; we will work together to resolve the issue. If we cannot reach agreement, CREATING BRIGHTER FUTURES will refer you to someone who can help you. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human services.

D. Effective Date, Restrictions, and Changes to privacy policy

This Notice will go into effect on April 15, 2013. CREATING BRIGHTER FUTURES reserves the right to change the terms of this Notice and to make the new notice provisions effective for all PHI that we maintain. CREATING BRIGHTER FUTURES will inform you verbally and we will post a written copy of any new notices. You may also request a written copy.

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Acknowledgement of Receipt of Notice of Privacy Practices

I, , have read the HIPAA Notices of Privacy Practices and Understand my rights regarding my child's Personal Health Information (PHI) and Psychotherapy Notes and how this information will be used, as presented in the Privacy Notice.

I consent to the use and disclosure of my/my child's PHI/Program Information for purposes of treatment, payment, or other health care operations. I understand and agree to the legally imposed required disclosures and the stated office practices, which do not require my signature for disclosure.

Other uses of my child's PHI/Program Information will require an authorization from me for the specific intention of the disclosure.

Child's Name:

Your Name:

Your Signature: Date:

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Severe Weather Policy

Creating Brighter Futures strives to provide consistent services to our clients. On occasion, the driving conditions become too hazardous for our clients and staff to get to the center safely.

If we have received severe weather, the Clinical Directors and owners of CBF will consult and make the decision regarding if the center will close. A decision will be made by 6:00 am, and you will receive a text message from one of the Clinical Directors.
You may inquire about any possible closings by visiting the Creating Brighter Futures Facebook page. All messages will be updated with information to notify if the center is closing by 6:00 am.

CBF Clients are not deducted time from their CAP allotment for days that the center is closed.

Families will be allotted two (2) personal snow days per year. In the event of bad weather and CBF stays open, but you do not feel it is safe to make the drive in, you can use a personal snow day and you will not be charged, and it will not be deducted from your CAP allotment.

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Video & Picture Release

Please check and sign this form to indicate your level of consent/permission for Creating Brighter Futures to create and/or use photos and video footage recorded during therapy sessions or events at the center.

The client's name will not be used in association with session results nor will their name be included on the video footage. **This release will expire one year form the date of signature, or upon written notice to Creating Brighter Futures.**

Please check to note permission for each purpose.

Photo	Video	Purpose
☐	☐	Sharing with Parent/Guardian & Client File
☐	☐	In-Center Use/Client's Program Materials
☐	☐	Educational/Training Presentations
☐	☐	Marketing – Printed Materials
☐	☐	Marketing – Website
☐	☐	Social Media

Client's Parent/Guardian will be consulted about the use of photos and/or video recording for purposes other than those listed above.

- ★ I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain supports and services from Creating Brighter Futures.
- ★ I understand that I may withdraw my authorization at any time by providing written notice to Creating Brighter Futures. I understand that such withdrawal of my authorization may not be effective to prevent disclosure of information previously authorized or to stop previous action that has been taken in reliance on this authorization.

Client's Name:
Parent/Guardian's Name:
Parent/Guardian's Signature:
Date:

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Safety Control Procedure Implementation and Release Plan

Client Name: DOB:

Creating Brighter Futures utilizes the Quality Behavioral Solutions, Inc "Safety Care" package for behavioral safety. This plan outlines the criteria for safety control procedure implementation and release as specific to this client.

Criteria for Safety Control Procedure Implementation:

when Displays behavior that may harm themselves or others and/or result in significant property damage, crisis management techniques will be used as a temporary safety precaution. These techniques involved physical restraint according to QBS procedures to maintain the safety of others and the client. All adults that work with have been trained in several physical management techniques.

Criteria for Safety Control Procedure Release

Safety control procedures will be released when does not engage in physical aggression, property damage/destruction for a 10 second calm count.

Crisis Management Documentation

When a crisis management technique is used; the date, time, duration, and the adults involved will be documented. If any injuries occur to or the adults working with they will also be noted. Each day, the parent/guardian will be notified regarding the total frequency of the safety control procedures that were implemented. 's parents/guardians will be notified by written or verbal communication the same day crisis management techniques are implemented.

Parent/Guardian Approval:

I understand that if the safety control program criteria (as defined Above) is met, that a safety control procedure will be implemented and released according to the release criteria (as defined above), as well as how I will be contacted regarding het occurrence of safety control procedure implementation. I understand that I Can contact the Clinical Director, Jessica Irish at 734-926-0740 if I have any questions about this plan or would like to withdraw my consent or the procedure(s).

Parent Name:

Parent Signature: Date:

Creating Brighter Futures

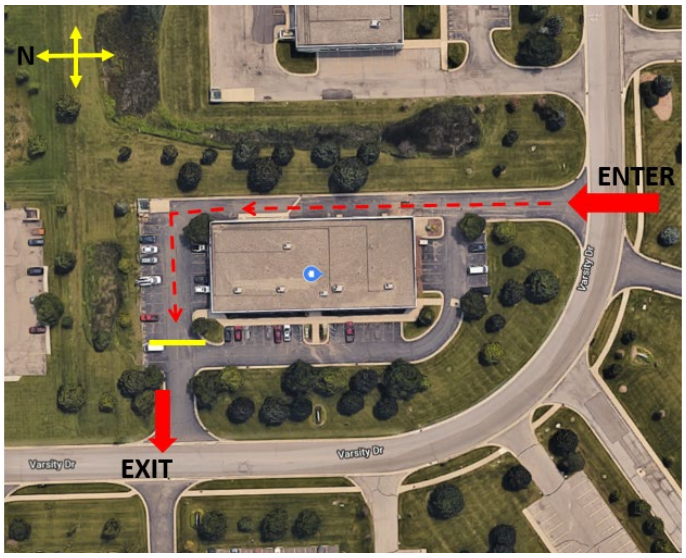
4201 Varsity Drive
Suite B & C
Ann Arbor, MI 48108
(P) 734-926-0740
(F) 734-369-8851

CBF DROP OFF & PICK UP PROTOCOL

Due to our limited parking spaces and the majority of our clients being dropped off and picked up at the same time, we have devised a plan to make the drop offs and pick-ups at this time go a little smoother.

IF YOU ARE DROPPING OFF OR PICKING UP FOR ABA AT 8:30 AM AND/OR 4:00 PM:

- Enter through the South drive way.
- Pull around the BACK of the building and up to the sidewalk along the North side of the building.
- Please wait in your car.
- A CBF employee will be outside to radio in to your child's therapist to let them know of your arrival.
- A CBF Employee will assist your child to enter/exit your vehicle.
- A CBF Employee will bring a clip board out for you to sign your child into/out of therapy.
- Once your child has safely exited/entered your vehicle, exit the parking lot through the West driveway.



Other Guidelines

- If you need to bring something inside the building or you need to have a conversation with your technicians' therapist or BCBA, please park in the front of the building and walk your child inside.
- If your child's therapy starts or ends at times other than 8:30 or 4:00, please continue to park and bring them into the lobby.
- Please be patient and considerate of the other parents!