Dr. Colleen Ryan, PhD
Licensed Clinical Psychologist
Autism Spectrum Disorders Specialist

Childhood Autism Treatment Team
P.O. Box 192, 119 Mill Rd
Palmyra WI 53156
www.chattautism.com

262-370-7744 (Scheduling) **262-370-5527 (Billing)** **262-495-3005 (Fax)**

CHATT Child Information Form

Name of Child_____

Date of Birth _____

Address_____
_____

Telephone numbers (please list all contact numbers and specify type)

_____
_____

Name of mother _____

Name of father_____

Name and Address of nonresidential parent (if applicable)
_____
_____

Names and ages of siblings residing in the home
_____
_____

Please list names and contact information for other family members or caretakers with whom we may be working
_____
_____

I understand that I may revoke this consent at any time except to the extent that it has already been acted upon prior to my revocation. Revocation will be honored upon written notification.

CHILD HISTORY FORM

CHILD NAME:_____

DOB: _____ SERVICE START DATE WITH CHATT:_____

WHO DOES THE CHILD LIVES WITHN (include siblings)? _____

_____

PLACE OF BIRTH: _____ CURRENT CITY: _____

PREGNANCY INFORMATION:

a. Was this a full term pregnancy? _____
b. Were there any complications during this pregnancy? _____
   _____
   _____
c. Was there any drug/alcohol use during this pregnancy? _____
   _____

MILESTONES & AGE REACHED (approximate age is okay):

a. Sitting: _____
b. Crawling: _____
c. Walking: _____
d. First words: _____
e. Other: _____
   _____

DIAGNOSIS:

a. What is your child's diagnosis? _____
b. When was your child diagnosed? _____
c. Where was your child diagnosed? _____
d. Who diagnosed your child? _____
e. Are there other diagnoses, what are they and are they being treated? _____
   _____
   _____

WHAT WERE THE PROBLEMS/CONCERNS THAT LED TO INITIAL DIAGNOSIS?

DID YOUR CHILD RECEIVE SERVICES PRIOR TO CHATT & WHAT WERE THE DATES OF SERVICE (Birth to 3, Private/Self-Pay Therapy)?

IS YOUR CHILD ON ANY MEDICATIONS (please include dosage, what s/he is taking it for, and start date; history of past meds)?

IS THERE ANY FAMILY HISTORY OF DEVELOPMENTAL DISORDERS OR MENTAL ILLNESS?

WHAT ARE YOUR GOALS FOR TREATMENT?

SHORT TERM GOALS?

LONG TERM GOALS?

IS THERE ANYTHING ELSE YOU WANT TO SHARE WITH US TO KNOW ABOUT YOUR CHILD?

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RELEASE OF INFORMATION AUTHORIZATION

Child's Name _____ Date of Birth_____

Street Address_____ City_____ State_____ Zip Code_____

*I hereby authorize*_____*(*Provider) *to:*

Check All That Apply:

☐ Release To ☐ Exchange with ☐ Obtain from parties I have indicated below

Release/Obtain information: ☐ verbally only ☐ in written form only ☐ both verbally and in writing

Person/Organization receiving/communicating the information

_____

_____

_____

☐ Specific information released (list below) or ☐ Any Information

_____

_____

Date Range Applicable _____(start) to _____(end)

_____
Signature of parent or legal guardian

_____
Signature of witness

_____
Date

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Emergency Plan:

If team members are in your home during a tornado warning, where should we go?

In the event of a house fire, please describe all escape routes in your home.

Do you have fire extinguishers? If so, where are they located?

In the event of an emergency involving a member of your family, whom should we contact?

What are the contact numbers for local police and fire departments? Hospital / Emergency?

Childhood Autism Treatment Team / Childhood Autism Therapies

Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 1-1-2011

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/therapist on _____(date) and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

  _____

- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):

  _____

Signature of Employee Completing Form: _____

Date Signed: _____

CHATT / CHAT Insurance Verification & Coverage Form

Child Name/Names_____

Parent/Family_____**Phone#**_____

Parent/Insured Address_____

City_____**State**_____ **Zip**_____

[ ] My child/family does not have private/employer-provided health insurance. Please bill the autism waiver program directly for therapy services rendered* If I have a Medicaid/ForwardHealth Card, I include copies of both sides with this letter. (*I understand that if evidence of insurance coverage is subsequently brought to light I will be responsible for paying back CHATT for service hours CHATT has billed and must retroactively pay back to WPS or the County because of my lack of disclosure, and I will need to seek insurance reimbursement from my insurance company for those service hours myself. If I have a Medicaid/ForwardHealth Card, I include copies of both sides with this letter.)

[ ] My child/family has private/employer provided health insurance, and I have provided the required information for billing it below. As required by the autism waiver program, please bill my private insurance first, before seeking reimbursement from the waiver. I attach copies of both sides of my insurance card with this letter.

Parent/responsible party signature_____**Date**_____

Insurance Payment Authorization/Signature on File Authorization

Primary Medical Insurance Company: _____
(Please include copy/copies of both sides of insurance card with this form, or scan/photo and email to cryan12@msn.com. Do not fax).

I hereby authorize you [insurance company(s)] to pay directly to the below named office benefits due to me out of indemnity under the terms of my policy issued by your company, or benefits due under the terms of any separate service and payment agreement negotiated between [insurance company(s)] and below named office(s).

Childhood Autism Therapies LLC DBA Childhood Autism Treatment Team (CHATT). Director: Colleen Ryan, PhD. Business Director: Mike Rubingh.
(1) N1563 CTH H, Palmyra WI 53156. (2) 119 Mill Rd, PO Box 192. Palmyra WI 53156.. Phone: 262-370-7744, Billing Phone: 262-370-5527, Fax: 262-495-3005

I authorize the use of this form for any current and future medical insurance submissions, with payment made directly to the doctor/doctor's business. I authorize the use of this form for any release of information required by CHATT/CHAT. I permit a copy of this to be used in place of the original. Payment by insurer(s) of the amount billed by CHATT for therapy, in whole or part, shall be considered the same as if paid, by your company, directly to me (the insured). I submit the following data:

Patient Name:	Patient DOB:
Insured Person Name:	Insured DOB (if different):
Insurance ID#:	Insurance Policy#:
Employer or School Name:	Insurance Group#:

1. I understand I am ultimately responsible for payment in full for services provided by the therapists of CHAT. I authorize CHAT to act as my agent in helping me obtain payment from my insurance carrier(s). Eventual coverage and reimbursement will be determined by your insurance carrier, plus any supplementary amount authorized by the waiver program. I understand I will be responsible for unpaid charges if lack of payment results from my providing CHATT with false/misleading insurance information
2. I understand that CHATT, as a typical provider may bill me for any co-pays and deductibles not paid by insurance unless the waiver program expressly forbids it. If I decide voluntarily to end waiver eligibility, I will be responsible for any co-pays and deductibles not paid by insurance or the state that are due to CHATT for services provided. I will inform CHATT of any insurance changes or job changes that may affect my insurance coverage before or within 7 days of that switch so the best response to ensuring continuing therapy can be made. I understand that if I do not inform CHATT of insurance changes that lead to denial of payment within the 7-day limit, I will repay CHATT any amounts billed after that date, and will seek reimbursement from my insurance company myself.

I agree to the above billing policies and authorization for billing.

Patient _____ Date_____

Parent/responsible party signature_____Relationship to patient_____

Childhood Autism Treatment Team / Childhood Autism Therapies - Timesheet 2017

Client Name:

Therapy Month: Senior Completes last three columns

Therapist Name (signature)	Work Date	Time In	Time Out	Hours Worked	Travel Hours (senior only)	Staffing Code (PM, FG, TM. Blank = BT)	Monthly Total Direct Hours (no travel)

Employee Signature	(Total Hrs for Month)	

Senior Staff: Collect, Validate Data, &

Submit monthly by 5th of next month

Scan/Photo+Email to: cryan12@msn.com

text msg to 262-370-5527 or fax to 262-

495-8689. or Mail to: Colleen Ryan,

N1563 County Rd H, Palmyra WI 53156

(Contact Mike R. 262-370-5527 with any issues)

Family/Guardian Signature: **Date:**

Childhood Autism Treatment Team / Childhood Autism Therapies
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Officer who is Mike Rubingh, 262-370-5527

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the

practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **emailing restriction request to cryan12@msn.com**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Mike Rubingh** at (262)370-5527 or cryan12@msn.com for further information about the complaint process.

This notice was published and becomes effective on **1-1-2011.**